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MEDICINE

JULY 1988

AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

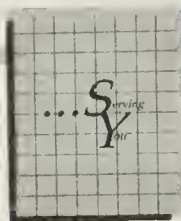
VOL. 87, No. 7

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M I C H I G A N MEDICINE

JULY 1988 VOL. 87, No. 7

Special Report

MSMS members continually question Blue Cross Blue Shield of Michigan policies and programs. Such has been the case since the management of Blue Shield passed from the hands of physicians many years ago and the company merged with Blue Cross to form one giant corporation. Recently, major structural and leadership changes have rocked BCBSM. MSMS leaders believe many questions could be resolved with a straightforward presentation of BCBSM policies and practices. To help members better understand how the Blues work, particularly regarding physician reimbursement, *Michigan Medicine* presents this month's special report.

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Cover photo courtesy of BCBSM.

Doctors and the Blues: real changes must come about

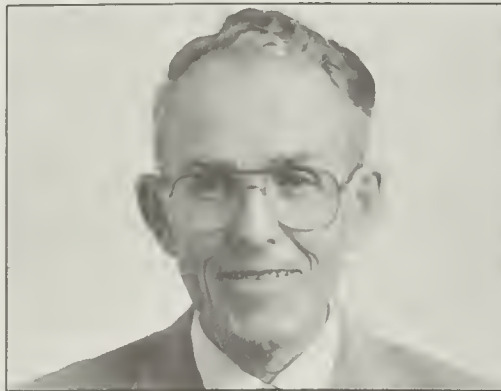
By Leland E. Holly, MD

Over a period of years dating back to 1968, I have been impugned as an implacable foe of Blue Shield and Blue Cross Blue Shield of Michigan. I can understand that, and, truthfully, often enjoy the reputation. At least everyone knew where I was coming from.

My side has always been the doctor's side, but the reality of the financial power of the monopoly enjoyed by the Blues, particularly in Southeastern Michigan, made it appear otherwise to many. To criticize and disparage the Blues, however constructively, was to bite ungratefully at the hand that paid most of the doctors' (and hospitals') bills.

The same situation exists today. Sure, the environment is dif-

Doctor Holly is a member of the MSMS Committee on Publications.



Doctor Holly

ferent, but we still give our support to the Blues because so many of us are so financially dependent upon them. To me, this begins to appear as some form of prostitution.

There must be something more to the practice of medicine!

It has always been my basic belief that a physician's most

sacred responsibility is to steadfastly perform as patient advocate and scientific healer. In respect to the Blues, physician performance has needed redemption since 1965. The indifference and intransigence of the Blues, who have relied on our compliant response to their largess (no matter how fickle), has always prevented that happy event.

Redemption requires that real changes must come about in the relationship between doctors and the Blues. There may not be an opportunity for this to occur. A basic requirement is fundamental change in the philosophy, objectives and actions of the Blues' management and Board. A meaningful role for physicians must be offered and truly supported. Only when MSMS has that guarantee can we begin to be whole. □

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Michigan malpractice premiums worse than they appear

In the May 17, 1988, issue of *Medigram* I read with interest the fact that physicians in the state of Michigan are paying a disproportionate amount of malpractice insurance in order to bring service to the citizens of the state. What is not as well known however, is that the insurance allowances from Blue Cross Blue Shield and from Medicare here are the lowest in the nation. They are at least twice as high in surrounding states of Ohio, Indiana, and Illinois. This makes the Michigan malpractice insurance premiums even worse than they appear, since as a percentage of gross income, the malpractice premiums that we pay in this state are compounded.

It may be doing a service to our membership if this fact were also disseminated to the public.

A. Joseph Hoski, MD
Warren

Medical director needed

The North Carolina Medical Society is now undertaking a nationwide search for a full-time medical director to head its newly-expanded physicians health and effectiveness program. The position may be filled as early as September of 1988.

Basic requirements are:

Continued on page 450

Michigan State Medical Society

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MSMS liaison committee is making strides with the Blues

By Susan E. Adelman, MD

The Michigan State Medical Society established a Liaison Committee with Blue Cross Blue Shield of Michigan in 1986 just before the BCBSM Board was restructured and reduced.

Before Michigan Public Act 350, passed in 1980 and implemented in November 1986, the BCBSM Board had 47 members, including seven MDs and three DOs. The board which replaced it in 1986 has two MDs and one DO.

Previously, physician input to BCBSM flowed through the Professional Relations Committee, whose members included all the doctors on the board. To provide for a comparable exchange of information, the Liaison Committee was created, with nine representatives from MSMS and three from BCBSM. In eight meetings over the last year and a half, the committee has dealt with a number of problems with BCBSM procedures and policies, and it has responded to over 75 individual physician complaints. In addition, over 150 individual physician concerns have been handled by MSMS and BCBSM staff, without specific presentation to the committee.

The MSMS Liaison Committee also has maintained an active, continuous interchange with the specialty society liaison committees, trying wherever appropriate to minimize duplication of effort.

Doctor Adelman is chairman, MSMS Liaison Committee with Blue Cross Blue Shield of Michigan.



Doctor Adelman

"The committee has dealt with a number of problems with BCBSM procedures and policies."

Some of the accomplishments of the Liaison Committee already have been published in *Medi-gram*, including the following:

1. BCBSM has agreed to modify its requirement, and recently announced that all physician notes and reports must be signed personally by the physician in order to qualify for payment. BCBSM now has agreed to conform to the guidelines of JCAHO, which allows a signature stamp to be used by the physician.

2. BCBSM announced in 1985 that it no longer would pay for the Michigan Health Benefits Claim Form (#1500). In response to MSMS objection to this policy, BCBSM agreed to provide these forms free of charge again to participating physicians. While this

is not a complete victory, it alleviates the problem nevertheless for some 60 percent of the physicians in the state of Michigan.

3. The Medicare Explanation of Benefit (EOB) form previously issued by BCBSM contained objectionable language which was modified to be in conformance with a resolution passed at the 1987 MSMS House of Delegates.

4. The grievance procedures used by BCBSM for appeal of physician audits were unevenly implemented, and not available to physicians in written form. Now, through the efforts of the Liaison Committee, a formal grievance procedure is being finalized, and we have the assurances of BCBSM that it will be published for all physicians to read. A draft has been reviewed by the Liaison Committee. It appears that it will introduce an element of consistency and accountability to these dispute resolution processes.

5. BCBSM was mandated by Michigan Public Act 350 to develop 20 specific Provider Class Plans. At the hearing for the Physician Provider Class Plan held on May 18, 1987, before the Insurance Commission, the MSMS Liaison Committee presentation emphasized four points:

1. There is abundant evidence that BCBSM payment levels for physicians are far below those of surrounding states. We asked the Insurance Commissioner to insist on comparability in payment with surrounding

states with the Provider Class Plan.

2. We have requested a fair and consistent appeals process within the Provider Class Plan.
3. Consistent with a resolution passed at the 1987 House of Delegates, we requested payment of interest to physicians at a rate comparable to that stipulated in P.A. 350 for payment to patients.
4. We have requested BCBSM to establish a decentralized communications network to address individual physician concerns in a more personal manner.

The Provider Class Plan for physicians was upheld intact by the Insurance Commissioner, but we were informed that our concerns had been heard. The change in the appeals process is being completed. The Liaison Committee has been informed that the comparability of payment issue is well understood by BCBSM. Due to antitrust considerations, however, BCBSM officials have said they are concerned about sharing the results of any study of this matter that they might undertake. Establishment of decentralized facilities within Michigan to permit direct contact with physicians has been discussed extensively within the corporation.

The committee has received numerous complaints about BCBSM's unilateral changes in billing codes. We have consis-

tently indicated that we believe this policy is wrong. BCBSM representatives on the committee understand our position, and they have taken it back to the corporation. So far the issue has not yet been resolved.

The new procedures for payment of anesthesia benefits, which were developed by BCBSM in consultation with the

**"MSMS hopes that
...it can assist
BCBSM to do its job
better..."**

Michigan Society of Anesthesiology, have been reviewed by the Liaison Committee. We are following closely the implementation process.

A number of concerns have been brought by the Michigan Psychiatric Society to BCBSM, and the Liaison Committee has consulted extensively in these discussions. The issues include confidentiality in psychiatric audits, implementation of Central Diagnostic Referral systems (CDRs), calculation methodology for non-acute psychiatric days, and BCBSM criteria for psychiatric inpatient and outpatient treatment.

Requests for new procedures codes and for specialty reimbursement changes are directed

by the MSMS Liaison Committee to the specialty societies. In some instances, the MSMS Liaison Committee had to determine which specialty society was appropriate for referral. At our most recent meeting, BCBSM representatives were invited at that time to provide MSMS with the opportunity to offer professional assistance in their ongoing reconfiguration of the programs.

Many of the problems of BCBSM are too broad in scope for the Liaison Committee. The management problems for instance, have been extensively covered by the press, and major changes now have been made.

There also is a serious question of the financial stability of BCBSM. Physicians of Michigan need to understand that Public Act 350 was designed to make BCBSM into a quasi-public corporation, and this has not had a salutary effect on BCBSM finances. In addition, numerous competitors are fast eroding the BCBSM market share. If the corporation cannot maintain its financial stability, there is a very real possibility that the state will take BCBSM over entirely. We then will see decisions about physician payments subjected to the vagaries of the state budget, and paid with the reliability of Medicaid.

The Michigan State Medical Society hopes that through the Liaison Committee it can assist BCBSM to do its job better, in order to allow it to remain at least a semi-private corporation. □

BCBSM puts financial house in order

By Larry J. Sell, MD

The future for Blue Cross and Blue Shield of Michigan (BCBSM) lies in its ability to successfully compete in an environment marked by rapid and radical change.

To be successful in this environment, BCBSM needs to be well managed, financially sound, cost competitive and efficient. It must also provide superior service.

Health care cost and use trends over the past 18 to 24 months that were unforeseen by virtually all in the health care industry have put a financial strain on BCBSM as they have on other Blue plans, health maintenance organizations and commercial insurance firms across the country.

However, recently-appointed BCBSM President and Chief Executive Officer Richard E. Whitmer is putting the corporation's financial house in order.

BCBSM has embarked on a \$100 million, two-year program to reduce administrative costs and, at the same time, has employed a nationally-known consulting firm to aid in restructuring the organization into a more efficient, service-oriented company.

Rates for group and non-group customers are being adjusted to reflect increased expenditures for cost of care.

Obviously, cost containment

BCBSM Financial Highlights (000 omitted)

	Subscription Revenue	Total Revenue	Benefit Payments	Operating Expenses	Expenses % of Income	Underwriting Result
1982	\$2,921,224	\$2,964,152	\$2,767,622	\$162,637	5.49	(\$9,035)
1983	3,099,527	3,156,392	2,878,096	169,500	5.37	51,931
1984	3,285,282	3,338,609	3,077,492	213,263	6.39	(5,473)
1985*	3,535,996	3,576,838	3,277,955	267,839	7.49	(9,798)
1986*	4,143,528	4,183,952	3,859,352	342,177	8.18	(58,001)
1987*	4,260,034	4,288,353	4,218,343	373,058	8.70	(331,367)

* Consolidated BCBSM and subsidiaries
Source: BCBSM 1987 Annual Report

programs can't be ignored. Nor can the political process, or the regulatory environment.

As long as BCBSM remains Michigan's largest single financier of health care, it will be drawn deeply into the political process. To a large extent, this political reality, and the regulatory scrutiny that accompanies it, is the price of success.

The future of BCBSM also depends on new relationships we can create and nurture.

Achieving them will not be easy. While many natural allies of BCBSM can see advantages in positive relationships with the corporation, there is a built-in "natural tension" between all industry participants. Interests at times conflict. BCBSM's role is to reconcile the conflict. The mastering of this balancing of interests represents an extremely important part of our program

for long term success.

As part of the process, the BCBSM board of directors has approved a new corporate mission statement submitted by Mr. Whitmer. A key point in his statement is "to cultivate with physicians, hospitals, and other providers relationships characterized by mutual respect, trust, and confidence."

The success of the joint Michigan State Medical Society and BCBSM Liaison Committee is proof this is no pie-in-the-sky dream.

The free exchange of ideas can lead to a resolution of problems.

We at BCBSM support its achievements and applaud all of its members, but especially the efforts of Doctor Susan Adelman, BCBSM board members Doctors Robert Black and Richard Rapport and MSMS Executive Director William Madigan. □

Doctor Sell is senior vice president, health care affairs, BCBSM.

The Blues' reimbursement system

By Judy Marr, Editor

Blue Cross Blue Shield of Michigan determines physicians' reimbursement today by a combination of the established usual, customary and reasonable (UCR) system and relative value schedules.

When did BCBSM initiate this combination system, why was it implemented, how does it work, and what's ahead?

Michigan Medicine recently asked those questions of BCBSM officials. Here are some of their answers:

Converting to relative values

When Larry J. Sell, MD, joined the company's staff in 1983, one of his major projects was to convert the Blue's reimbursement system to a relative value base.

The BCBSM senior vice president for health care affairs asked board certified panels of Michigan physicians from every specialty to join him in studying every code for reimbursed procedures. Together they determined a relative value associated with each code.

A relative weight is assigned to each procedure based on the knowledge, skills, experience, time and risk related to each service, Doctor Sell explains. Each procedure receives a weight relative to other procedures.

A procedure which has a greater weight (or higher index number) requires more effort or resources, or entails greater risk, than does a procedure with a

lower weight.

"It is complicated," says Doctor Sell.

"It's difficult to compare the skills necessary for one specialty to those needed by another, and then to interdigitate them into the system."

"Yet there is a clear relationship between our 11,500 codes," he declares.

The modified system became operational in October, 1983. It reduced payments for some major medical procedures, such as cataract surgery. The Blues, however, increased payments for cognitive services at that time.

And, in the first six months after implementing the current system, BCBSM staff and their expert physician panels reconsidered at least 200 relative values, as their knowledge of procedures was refined.

Moving toward a fee schedule

The change-over to the modified UCR/RVS system was necessary, explains Jeanne Carlson, director, BCBSM Cost Reimbursement Department, because the system previously was "charge-driven."

"Some groups of specialties were charging at increasingly higher levels, pulling the relationship with other specialties out of alignment," she says.

The previous system also did not allow for reevaluation of procedures, explains Doctor Sell. "If you don't continue to reevaluate, the initial high price for a new, unfamiliar procedure stays in the

system, even though the time required, difficulty of techniques and possibility of side effects may have decreased."

Using relative values tends to make the reimbursement system more equitable, points out Donald G. Bearden, DO, vice president, health care affairs administration and BCBSM medical director.

Doctor Sell said another reason for the change is that physicians have indicated to Blue Cross Blue Shield, on both national and state levels, that they would prefer to move toward a fee schedule.

The modified system helps BCBSM and physicians move toward that goal.

How the system works

Under the current UCR reimbursement system, explains Ms. Carlson, BCBSM pays physicians the lesser of three components:

- 1) What the physician bills,
- 2) What BCBSM has on file for the physician—the profile; and
- 3) The maximum screen for the procedure.

The maximum screen is computed by multiplying the relative value by a dollar conversion factor. It is similar to the "reasonable" portion of the old UCR system.

"We have a profile for physicians who do business with us, and a profile for every fee the physician charges," she says.

"We update these profiles automatically when we update the

Continued on next page

SPECIAL REPORT/Continued

maximum screens," she explains.

For many years, the Blues only updated physicians' profiles when the physicians requested it.

"We found that some doctors did not regularly request this service, and it was throwing off the balance between physicians," Ms. Carlson states.

Another reason the Blues went to automatically-updated profiles, Ms. Carlson explains, is to treat physicians in all parts of the state more equitably. The differential in payments between Michigan's two zones (southeast and outstate Michigan) thus has decreased from the 15.6 percent under the prior system to a current 4.4 percent.

"We found that many physicians in rural areas were seeing more patients but not giving us information to update their profiles.

"Their maximum screens were higher than those in Detroit, but their profiles were not being updated. They were being limited by their profiles."

Other cost factors

Doctor Sell emphasizes that there are factors in establishing cost of medical care—factors such as utilization, the explosion of technology, and the availability of equipment to perform services as well as malpractice premiums.

"The thing that is unique about health care," says Doctor

Sell, "is that 85 percent of the time the person who determines use is the provider. It's likely that a patient demands a particular service.

"We learned the impact of that factor when we froze reimbursement. Utilization of services increased and our overall cost of

"Some physicians are upset with BCBSM. . . But if a procedure is not a covered benefit, BCBSM cannot reimburse for the service regardless of validity or need."

health care in Southeast Michigan went up."

The freeze, explained Doctor Sell, was an attempt to hold down the Blues' overall payout. It did not work, he said, because the number of reimbursable services provided by physicians increased. To contain cost, BCBSM officials now believe the answer lies with more utilization, not price controls.

In fact, if physicians' utilization were truly efficient, BCBSM officials say, prices probably

would go up.

"If we could really control the use," says Doctor Sell, "we would be delighted to give the physicians a little bit more money for each service."

Sixty-five percent of Michigan physicians formally participate in Blue Cross Blue Shield of Michigan programs, and the figure grows to 91.2 percent when per-case participation is included.

MSMS records indicate that one of the biggest questions raised by physicians about their personal BCBSM reimbursement is how it compares to that of physicians in surrounding states?

A study by an independent firm is helping BCBSM make that comparison on a broad scale.

Blues cover only what the customer orders

The Blues pay only for the benefits their customers write into their contracts, emphasizes Doctor Sell. Some physicians are upset with BCBSM when they find a procedure is not reimbursed. But if a procedure is not a covered benefit, BCBSM cannot reimburse for the service regardless of validity or need.

"The variations (in contracts) are immense," points out Doctor Sell. "Before we can pay for a benefit, our customers must say they want it."

Physicians do have the ability to suggest changes in reimbursement for new procedures or covered benefits, however. BCBSM has an established procedure for

such suggestions.

For a new procedure to be a covered benefit, BCBSM prefers the process start with a written request from a medical specialty society. The BCBSM Medical Policy Interpretation Department, headed by Melvin J. Anderson, DO, will provide an application form.

When that form is completed, BCBSM begins researching the new technique, medication, instrumentation or other breakthrough. This includes review of BCBSM's extensive files on most procedures.

The company studies the physicians' documentation, reviews the request with the Blue Cross and Blue Shield Association Technology Evaluation Committee, and consults the appropriate physicians among the 80 outside consultants employed to advise on these matters.

The final step is to present the possible new procedure as a covered benefit to the customer. If the customer agrees to include it in its contract, the procedure is covered.

"If a proposal is denied, it can be reviewed again at the Evaluation Committee level, on the request of the sponsoring organization or BCBSM itself," says Doctor Anderson. "This review can come in six months to two years."

There were more than 30 new procedures added as covered benefits to BCBSM customers' contracts in the past year, according to Doctor Anderson.

"In reviewing and auditing bills for payment, BCBSM asks three questions: Was the procedure actually performed? Was it medically necessary? Was it performed in the proper setting?"

BCBSM audit procedures

In reviewing and auditing bills for payment, BCBSM asks three questions: Was the procedure actually performed? Was it medically necessary? Was it performed in the *proper* setting?

Proper setting can be defined as inpatient when appropriate, outpatient when appropriate, or a qualified, free-standing facility when appropriate.

The Blues have two types of audits—one is financial (performed only on those providers who are cost-reimbursed, such as hospitals and other facilities), and the other is for medical necessity.

Still another review is made of utilization, with auditors visiting physicians' offices to make sure that what is billed actually was delivered, that it was medically necessary and that it was performed in the proper setting.

Financial and medical neces-

sity audits are performed simultaneously.

The Blues audit approximately 250 physicians per year. If they find abuses, remedies can be sought. The Blues have new computer programs to spotlight physicians for auditing.

"We have determined that three percent of providers receive 30 to 35 percent of the reimbursement," says Doctor Sell. "Historically, most professional providers consistently play well within the rules. A small percentage are entrepreneurs, who most often work with the system and within the law.

"We work with them, but initiate corrective action and recovery when needed.

"One to 1.5 percent of providers consistently show billing aberrances, and in that group, a

Continued on next page

SPECIAL REPORT/Continued

smaller portion will present true fraud problems."

Future reimbursement trends

What do the Blues officials predict for the future?

"There seems to be a relatively solid cap on what this country is willing to spend on health care," observes Doctor Sell. "Thus we are very concerned whether the explosion in costs we saw in 1987

smaller group of providers. We may choose not to do business with the truly aberrant physician or facility. Our customers have given us the right to do so."

"Inflationary trends nationwide don't look good," Doctor Sell said. "We don't like what we hear, our customers don't like it, and it's our job to see it doesn't happen here, if at all possible."

After all the cautionary lan-

guage, however, Doctor Sell ends his comments on an upbeat note.

"The most little-known fact in the state," he said, "is that Michigan offers some of the world's finest health care and the world's finest health care providers."

"It always amazes me to see how well known and how well respected the physicians of Michigan are in other states. It's a compliment," he said. □

"Michigan offers some of the world's finest health care..."

will continue in 1988-89.

"We are looking at the whys of this explosion. There could be a ton of reasons—society's insatiable appetite for Mayo Clinic-level treatment, the growing number of senior citizens, increased technologies, increased covered benefits."

On the physician side, he reiterated, BCBSM anticipates a continued look at the relative value system, and a move towards a fee schedule.

"From the company's side, we could find ourselves in a few years doing business with a

BCBSM factsheet

The following BCBSM facts and figures are based upon information provided by BCBSM in its 1987 annual report.

- At \$4.2 billion in subscriptions, revenue was up by 2.8 percent over 1986, while benefit payments plus operating expenses were up by 9.3 percent. Net underwriting expenses constituted a loss of \$331,367,000, down 471 percent from 1986. The number of enrollees dropped by 3.1 percent to 4.7 million.

- Cost per 1,000 members for physician services rose by 10.5 percent, compared with a 7.1 percent increase for inpatient care and a 20 percent increase for outpatient care.

- For its private business alone, BCBSM processed 57 million claims in 1987, up 2.6 percent from 1986. Acting as the fiscal intermediary for Medicare, BCBSM processed an additional 18 million claims in 1987.

- With a net operating loss of \$330 million, 1987 marks the fourth consecutive year BCBSM has lost money. The Blues lost \$58 million in 1986, \$9.7 million in 1985, and \$5.4 million in 1984.

- BCBSM outpatient visits rose to 712 per 1,000 members in 1987, a 15 percent increase from 1986. The average payment per outpatient visit was \$183 in 1987 compared with \$174 in 1986.

- The number of services provided by physicians grew by five percent to 4,385 per 1,000 members, with an 11 percent increase in costs for these services to \$215,200 per 1,000 members.

- The average hospital payment per inpatient rose by 12 percent, to \$677 per day. Inpatient admissions rose by four percent to 96 per 1,000 members, while the average length of stay declined by eight percent to 5.5 days. □

An explanation of the Blues' utilization review process

By Charlotte Bartzack, PhD

Blue Cross and Blue Shield of Michigan (BCBSM) has developed an integrated utilization review process to deal with utilization problems in a cost-effective manner. The process incorporates a multifaceted strategy including such elements as education, alternative reimbursement concepts, predetermination, and prepayment utilization review. BCBSM is constantly developing, modifying and enhancing the process.

Potential audit candidates are primarily selected from periodic specialty, procedure and aberrancy analyses conducted to evaluate current utilization patterns. These analyses permit identification of the specialties and procedures demonstrating questionable utilization patterns and ultimately lead to the selection of audit candidates.

BCBSM also utilizes its Professional and Facility Aberrancy systems to target potential audit candidates. These automated systems were developed to ensure early and cost-effective identification of:

- Individual providers rendering questionable services;
- Specific changes in utilization patterns, with identification of individual providers leading a given change; and
- Comparison of providers to their peers by specialty and location.

"BCBSM has developed an integrated utilization review process to deal with utilization problems in a cost-effective manner."

Once a provider is targeted for on-site review, the utilization review staff determines the audit scope (i.e., total practice, inpatient, outpatient, office, etc.) and appropriate sample size.

Sound statistical sampling techniques are utilized in those instances wherein audit samples are drawn from a defined universe.

Notification of audit

In most instances, the provider receives written notification of BCBSM's intent to audit at least two weeks in advance of the scheduled on-site review. The audits are conducted by the BCBSM utilization review staff which consists of registered nurses and other trained professionals with considerable health care

delivery backgrounds and audit expertise.

The on-site audit process begins with an entrance conference at which time the provider receives the audit specifications (e.g., projected time table, work space requirements, required records, etc.). During the entrance conference, the provider will be asked if there is any objection to BCBSM photocopying the patient's medical records. If BCBSM is allowed to photocopy medical records, the amount of time required to perform the on-site review will be substantially reduced thereby expediting the entire audit process. Furthermore, it is in the provider's best interest to allow records to be photocopied as all medical necessity issues are reviewed by BCBSM medical consultants. The consultants will be in a better position to assess the appropriateness and necessity of the care from a photocopy of the medical record as opposed to a handwritten interpretation/extraction.

Purpose of on-site review

At the conclusion of the entrance conference, the auditor proceeds to review the medical records and other related documents (e.g., x-rays, laboratory results, etc.) of the sampled patients. If BCBSM is unable to obtain photocopies, key medical information is captured on worksheets and later reviewed by a

Continued on next page

SPECIAL REPORT/Continued

BCBSM medical consultant. The primary objective of the on-site review process is to ensure that paid services were: ordered; rendered; billed properly; necessary and appropriate to the patient's condition; and covered under the patient's contract.

During this process, the auditor assesses utilization patterns. In the event of prior audit activity, current findings are compared to prior audit findings to assess the effectiveness of the provider's corrective action measures. Finally, the auditor evaluates the provider's procedure protocols and equipment to determine whether the provider has the instrumentation required to render the services billed to BCBSM.

An exit conference is conducted with the appropriate provider representatives at the conclusion of each on-site review. Discussion includes, but is not limited to, a synopsis of the audit findings. If irregularities are identified, emphasis is placed on potential problems/patterns. Potential provider sanctions (e.g., recovery, prepayment utilization review, etc.) and required corrective action are discussed as well as BCBSM's appeal process.

Medical necessity issues/questions arising out of the on-site audit are then referred to a BCBSM medical consultant for review and determination. Upon receipt of the consultant's determinations, an analysis is con-

ducted to determine the extent of liability. In the case of statistically valid samples, the results are projected to the universe.

Reconsideration of review findings possible

Upon completion of the internal analysis, the provider receives

“Medical necessity issues/questions arising out of the on-site audit are then referred to a BCBSM medical consultant for review and determination.”

written notification detailing the audit findings and required corrective action as appropriate. If recovery is warranted, the provider is given 30 days from the date of the letter to repay the amount in question, arrange for alternate repayment terms or request an additional review of the initial audit findings (Reconsideration Review). This review will be performed by a physician not involved in the initial determination. Requests for reconsideration must be submitted in

writing and include:

- area of dispute;
- reason for disagreement;
- any additional supportive documentation; and
- copies of medical records (if copies have not already been obtained).

If the provider is dissatisfied with the results of the reconsideration review, a formal appeal process may be initiated. The first step in the appeal process involves a review by an external body, presently the Physician's Review Organization of Michigan (PROM). If still dissatisfied, the provider may continue with an appeal to the Internal Review Committee and finally to the Provider Relations Committee of the BCBSM Board of Directors.

Additional sanctions/actions which can be applied as a result of the audit activity include, but are not limited to, the following:

1. **Departicipation**—The provider's participation agreement is terminated and all future claims must be submitted as pay subscriber.

2. **Prepayment Utilization Review (PPUR)**—All future claims must be submitted with supportive documentation and will be manually reviewed for payment.

3. **Potential fraud** is referred to Corporate Financial Investigation.

4. **Provider Monitoring**—Future claims are monitored on a weekly, monthly or quarterly basis to determine if corrective action has been implemented. □



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Possible changes ahead in BCBSM appeals process

By Rude DiFazio

Blue Cross and Blue Shield of Michigan (BCBSM) is reviewing its appeal structure as part of a major reorganization of the corporation that is now underway. The reorganization study is part of a program to improve efficiency while cutting administrative costs by \$100 million over the next two years.

The company anticipates that within the next few months the reorganization study may lead to

consolidation of some of the appeals process and the possible change of points of contact with the corporation for those physicians seeking to appeal BCBSM decisions.

When the reorganization study is complete, BCBSM will notify all providers of care of changes. In the interim, the company recommends that physicians continue to contact the corporation through established provider inquiry channels:

- **Regular business and complementary coverage:** (313) 225-8211 (Detroit area); 1-800-482-3146 (toll free).

- **General Motors:** (313) 225-5940 (Detroit area); 1-800-233-4369 (toll free).

- **Medicare:** (313) 225-8222 (Detroit area); 1-800-482-8760 (toll free).

- **Federal Employee Program Coverage:** (313) 225-0029 (Detroit area); 1-800-482-3600 (toll free).

In the case of audit, physicians are notified by mail of the name and telephone number of the BCBSM staff person conducting the audit. All inquiry contacts should be maintained with the staff person identified in correspondence. □

Mr. DiFazio is director, Media Relations, BCBSM.

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Executive Vice President



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Michigan physicians' insurance rates highest in Great Lakes area

Editor's note: The MSMS Medical Economics Department recently conducted a study of medical malpractice rates in the Great Lakes area. Results of the study follow.

Michigan physicians must pay three to five times as much for medical liability insurance as their colleagues across the Indiana state line, according to a recent MSMS study.

Medical liability insurance rates in Michigan are higher than in any surrounding Great Lakes state, the study further shows.

Neurosurgeons in the Detroit area pay in excess of \$80,000 each year for a \$200,000 policy, the study found, while many outstate obstetricians/gynecologists have stopped delivering babies because their insurance costs cannot be covered by the number of deliveries performed.

For \$100,000 coverage, an obstetrician in a Michigan metropolitan area pays \$51,952. In Indianapolis, Indiana, that same obstetrician would pay \$14,408 for \$100,000 coverage; in Columbus, Ohio, \$18,570; and in Chicago, Illinois, \$34,255. In Milwaukee, Wisconsin, an obstetrician pays \$31,746 for a \$300,000 policy. A lower policy amount is not available there.

Most Michigan obstetricians carry a minimum of \$200,000 coverage, which costs about

\$68,274 in a metropolitan area.

Based on a 40-hour week, an obstetrician must earn \$34 an hour just to pay for insurance. Obstetricians' insurance rates have increased 406 percent in the past four years.

"It's no wonder that obstetricians graduating from our medical schools and completing residency programs are leaving Michigan," said MSMS president Frederick W. Bryant, MD, "if they can simply cross the Indiana border and pay a third of what they would pay in Michigan for medical liability insurance."

"Our medical school graduates are a priceless resource," Doctor Bryant said. "We need to do something to keep our energetic and enthusiastic young physicians in Michigan."

Ever-increasing numbers of lawsuits, increasing amounts of jury awards and resulting high insurance rates will continue to drive obstetricians from Michigan, according to MSMS Manager of Medical Economics,

Thomas White, who conducted the study.

Other Michigan physicians pay similarly high rates, he said, the amount depending on the specialty.

Malpractice insurance rates for Michigan and adjacent states for selected specialties in metropolitan areas are listed below, based on \$100,000 occurrence insurance policies. Illinois figures are based on a mature claims-made policy, which is the closest comparison to an occurrence policy.

General Practitioner, with no surgery: Indiana, \$1,695; Ohio, \$2,948; Illinois, \$7,060; Michigan, \$8,033.

General Practitioner, with minor surgery: Indiana, \$4,068; Ohio, \$9,256; Illinois, \$10,761; Michigan, \$22,642.

General Surgeon: Indiana, \$8,888; Ohio, \$15,328; Illinois, \$23,126; Michigan, \$30,187.

Obstetrician/gynecologist: Indiana, \$14,408; Ohio, \$18,570; Illinois, \$34,255; Michigan, \$51,952. □

Michigan malpractice rates top region*

	Michigan	Indiana	Ohio	Illinois
General practitioners (no surgery)	\$ 8,033	\$ 1,695	\$ 2,948	\$ 7,060
General practitioners (minor surgery)	\$22,642	\$ 4,068	\$ 9,256	\$10,761
General surgeons	\$30,187	\$ 8,888	\$15,328	\$23,126
Obstetricians-gynecologists	\$51,952	\$14,408	\$18,570	\$34,255

*Annual premiums



ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow,
Massachusetts General Hospital, Boston, Massachusetts.
Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude);
Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical
Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neuro-
surgery Research Fellowship Training, National Institutes
of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial
Fellowship, National Masonic Medical Research Foundation;
Albert Schweitzer Fellowship, International Albert Schweitzer
Foundation; Harvard Medical School Cabot Prize for Best
Senior Thesis; recently published article, "Who Shall Live
and Who Shall Die" in Newsweek Magazine.



Soldier being examined for effects of high-altitude cerebral edema.

“The work I’m doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn’t ask for a smoother transition. And that’s true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

“Some of the projects the Army is undertaking are on the cutting edge of research. For example, I’m currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

“The quality of medicine and the caliber of people I’ve been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I’m giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General.”

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Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chloridiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Dral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch 8elbred rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established. **Use in Elderly Patients**—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

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Doctors! Wake up!

By Alfred B. Swanson, MD

Doctor bashing seems to be the latest vogue in the United States. Why is this happening and is it justified? What is this doctor person all about?

Well, who starts out as a young, loving human being intrigued with animals and in love with frogs, birds and bugs? Who later stands academically apart in grade school and high school, then goes on to college and medical school thinking of making a

Doctor Swanson is a Grand Rapids orthopedic surgeon.

career of helping the sick and suffering instead of a job oriented towards making a killing from the economy—or from “those that have?” Who must have a far above average scholastic record to apply to the residency training program and then compete with the best in the nation in an impersonal computer matching program? Who will invest five of the best years of youth to labor in hospitals for 100 hours a week at \$4.00 an hour in order to accumulate the knowledge and skills necessary to take a specialty exam

that only two-thirds will pass? (They then will have to be recertified periodically throughout life.) Who will ask a spouse and young children to suffer through years of economic and personal deprivation? A doctor! For what? To become one of our nation's medical specialists and compete for a practice with people already established in the best medical delivery system in the world? Who, before finishing training, will run up loans of \$50,000 to

Continued on page 447



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Metric Medical Labs and the Medical Genetics and Birth Defects Center at Henry Ford Hospital are pleased to announce a joint program of alpha-fetoprotein testing for detection of neural tube defects and Down Syndrome.

Further information on this program is available through Metric Medical Labs and Henry Ford Hospital.

Breaking into the "old boys" network

By Dawn Springer, MD

Michigan women physicians gathered on a Saturday recently in Ann Arbor to attend an MSMS workshop. The goal of the workshop was to provide women physicians with the strategies they need to become involved in the policy development of organizations whose decisions influence their professional and personal lives.

Approximately 50 women physicians looked at effective pathways to participation and decision-making, at networking, and at developing leadership/administrative skills.

Perhaps, we thought, we might work to break into the "old boys" network or form an "old girls" network!

Backing our thoughts were recent meetings of the MSMS Committee on Concerns of Women Physicians, and a 1986 poll the committee took of women physicians around the state.

The purpose of our spring workshop in Ann Arbor was to gain a greater understanding of ourselves, and to understand and appreciate differences in other people for the opportunities they bring. We sought:

- To apply our learning to work and personal relationships.
- To build the foundation for a strong, interactive group tailored to the needs of Michigan women physicians.

One of our members, Vivian



"I'm sorry you didn't expect a 'Lady Doctor,' Mr. Thorndyke... perhaps you'll be relieved to learn that I don't believe the way to a man's heart is thru his stomach."

Lewis, MD, of Flint, commented that the MSMS committee serves as an "incubator" for medical society leaders on local, statewide and national levels.

I initiated the following question and answer session with the workshop coordinator, Renee Lipson, PhD, of Lansing, to share her insight with a wider audience. The questions are mine, the answers are hers.

I believe that all Michigan physicians will benefit from this information. Please read on:

Springer: Please share some of your thinking on women physicians.

Lipson: Modern women physicians are intriguing. In other societies, such as the Soviet Union, women physicians are the majority. There, the stereotypical physician embodies supposedly womanly characteristics, such as personal involvement, compassion, maternal authoritativeness,

and patience in the face of long-term illness.

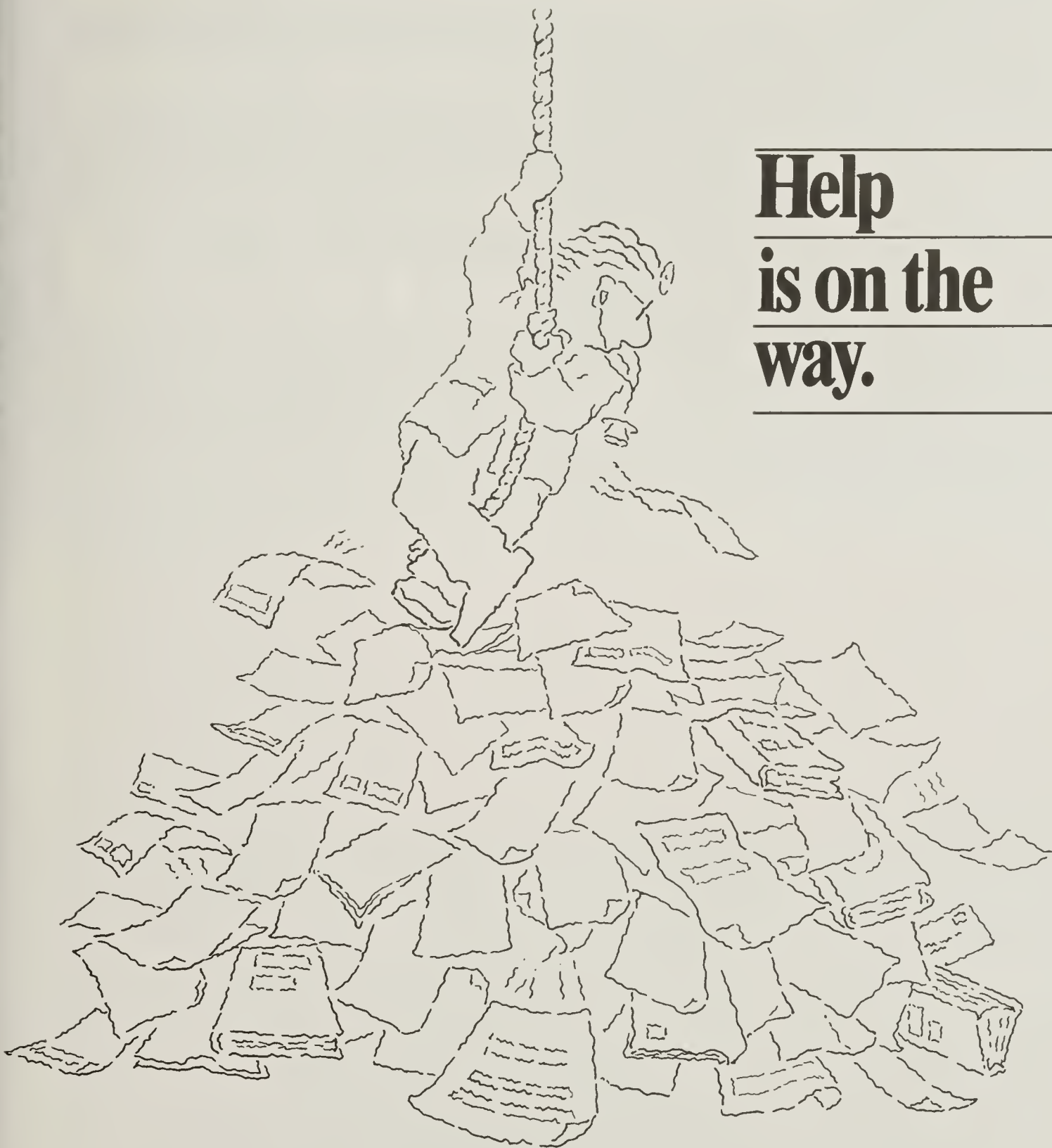
In the United States, until recently, women physicians have been rare. The typical physician embodies supposedly manly characteristics such as rationality, objectivity, technical authoritative-ness and aggressiveness in the face of emergencies.

The gender-typing of specialists also presents contradictions. In the US, women are urged to enter specialties with high patient-interaction, such as pediatrics or psychiatry, because such specialties supposedly are compatible with their interest in people. Women also are steered to low-interaction specialties such as pathology, anesthesiology or public health, because their practice hours are more compatible with their family responsibilities.

Doctor Springer is chairman, MSMS Committee on Concerns of Women Physicians.

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Help is on the way.

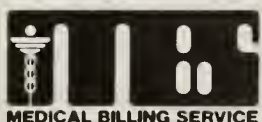


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NETWORK/Continued

Springer: What about women as leaders?

Lipson: I see women under-represented in positions of leadership, even when they are the majority of workers. Numbers alone do not answer the gender inequality question. I see three things as important for women physicians.

First, I think they don't know how to market themselves. A useful strategy is the deliberate presentation of self for advancement. In order to do this, women need self-assurance. They have to have contacts in places where decisions about advancement are made. And women, too, need the realization that merit is not necessarily its own reward.

It seems to me that younger women can promote themselves more easily, where more mature women physicians have been brought up in a culture to behave differently, so this is more difficult for them. As I work with women professionals in this area, I have often found this to be the case. Overcoming the attitudes with which we have been brought up is very difficult for many of us.

A second area of importance is networking. This is a role that the Committee can certainly help with. We got a wonderful start on it at the spring workshop. Meeting other women who can be helpful to you in a wide variety of ways, and being able to ask

for the support, are crucial for professional development and advancement. We know that individuals, both male and female, who have this support, advance far more quickly than those who do not.

The third area we need to look at is position in organizations. Women often feel that they don't have the sufficient background necessary for more advanced po-

"The political aspect of career advancement is a game of reciprocity."

sitions of authority. I believe leadership skills are learned skills, so practicing skills, after becoming more aware of those we need to learn and practice, becomes crucial.

I believe also in on-the-job training. Doing it will give us a much better feeling about ourselves than just reading about it or listening to it. That's how I ran the workshop, as a participative opportunity for developing skills.

The political aspect of career advancement is a game of reciprocity. Until women learn to look for sponsors, to be assertive and express their worth to potential sponsors to help them start in the issue of professional reciprocity, we will have this as a drawback.

Springer: What about informal organizations?

Lipson: If women are to gain positions of power, the patterns of the informal organization of the workplace must routinely include them. Women must accrue the resources and the reciprocal favors that advance careers and they must act politically as a group in order to defuse gender as a status issue.

One of the workshop goals was to experience our different styles and to learn to celebrate those differences for the opportunities they bring. We're looking at these differences in relation to our patients, to our colleagues, in the hospital, in academia and to our home environment. I believe the issues that we addressed at the workshop can be brought into every facet of our professional and personal life.

Springer: So what we've really done at the spring workshop is build a strong network for women physicians. We've begun to build a foundation for a community and professional coalition of Michigan women physicians. The group will build on and take advantage of their diverse backgrounds and develop strong linkages to generate ideas, resources and contacts.

Conclusion

The seminar's goal was to form a community and a professional coalition where members could learn and practice their skills in a safe environment. I believe this goal was accomplished. □

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Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



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Brief Summary of Prescribing Information

For Dermatologic Use Only
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INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see **DOSAGE AND ADMINISTRATION**). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see **PRECAUTIONS, Pediatric Use**). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetronide, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see **DOSAGE AND ADMINISTRATION**).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetronide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetronide Cream cleared or significantly ameliorated the disease state in most patients. *Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio.* HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetronide in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX[®] (Nystatin-Triamcinolone Acetronide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX[®] is usually applied to the affected area twice daily in the morning and evening. MYTREX[®] should be discontinued if symptoms persist after 25 days of therapy. (See **PRECAUTIONS, Laboratory Tests**). MYTREX[®] should not be used with occlusive dressings.

Caution: Federal law prohibits dispensing without prescription.



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Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: James E. Beale, MD

Action, Date Taken: Suspended 75 days/fined/limited, June 20, 1988

Reason: Drug related

Name: George Czertko, MD

Action, Date Taken: Probation 1 year, June 20, 1988

Reason: Mental or physical impairment

Name: Surinder Paul Jindal, MD

Action, Date Taken: Suspended 6 months & 1 day, June 20, 1988

Reason: Negligence-incompetence

Name: Robert C. McDougal, MD

Action, Date Taken: Suspended 6 months, June 11, 1988

Reason: Incompetency

Name: Richard T. Robinson, MD

Action, Date Taken: Suspended 60 days/fined/limited, June 20, 1988

Reason: Practice outside the scope of a license

Q.
A.

Heavy consumption of alcoholic beverages increases the risks of certain cancers.

True. Moderate consumption of alcohol—one or two drinks a day—does not seem to increase cancer risks. But heavy drinking is associated with cancers of the mouth, throat, esophagus, pancreas and liver. People who both smoke cigarettes and drink heavily increase their risks of getting cancers of the mouth and the esophagus.



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Say "YES" to medical auxiliary

By Joyce M. Mann
MSMS Auxiliary President

Editor's note: The following are excerpts from MSMS Auxiliary President Joyce Mann's inaugural address.

Say "YES" to medical auxiliary! That is the motto for my year as your MSMSA president. I'm hoping to hear a chorus of "YES's" from auxiliaries during the coming year.

Why is saying "YES" to medical auxiliary so important this year? Because medicine is chang-

ing—so rapidly we can hardly keep up with what is happening. The medical auxiliary must change as much and as fast if it is not to be left far behind.

I'm quoting from a speech made several years ago by Mary Strauss, soon to be president of the AMAA. She said, "MD means deity no longer . . . the physician's name is no longer gospel and the halo has lost some of its glow."

We are auxiliaries who have a job to do. Medical schools did not train physicians for the onslaught of medical malpractice suits,

mountains of paperwork for the government, public relations and peer review hassles. They were trained to do the best job possible for the care of patients. There is no one more personally involved in the daily problems of medicine than the spouses and families of physicians.

Auxiliaries can do plenty

Iris Constantine Carr, of the Massachusetts Medical Society,

Continued on next page

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AUXILIARY/Continued

wrote an article in *Facets* a few years ago:

"There was a time when physician's spouses could view the auxiliary as a social pastime. It ought now to come into its own as an adjunct and defensive organ to the American Medical Association and to the state medical societies... There is much that we can do to attract more of the spouses to join with us.

"We have individual talents that we can share. There are prominent physicians' spouses who have achieved recognition in their own fields. We can change the focus from fashion shows and travel tours to more pertinent inter-personal exchanges and to assistance in our local areas."

Male spouses increasing

Auxiliary already has changed greatly over these past years. But there is much more to be done. It is projected that in the future, at least one third of physician spouses will be males. The contribution of these men to the auxiliary could be enormous, if the organization can make them feel welcome.

It already has happened in Indiana. Last year, one of the county medical presidents in Indiana was a male; he now serves on the State Board. Last February in Chicago, I learned of one county in which a male member volunteered to use his expertise at fundraising for the benefit of the



Joyce Mann

"We should actively recruit spouses of female physicians into our organization."

auxiliary. But we should not just *let* it happen. We should *make* it happen. We should actively recruit spouses of female physicians into our organization.

Along these lines, MSMS has taken a positive stand on membership and has asked for volunteers to be recruiters. I am hoping that this following year we shall be able to emulate this program. I have been involved with membership for several years and feel that personal contact is still the most effective recruitment technique. I also am deeply concerned that the Auxiliary stay in touch with spouses of residents and medical students. This year, I have appointed a resident physician/spouse to the State Board.

I hope that all counties which have residents and medical students will do the same. We must remember that these young people are the future of our organization.

Speaking of the future, the future of medicine depends upon the resolution of the liability problems. Are we going to be able to help solve some of these problems? Are we writing enough letters to our legislators to let them know we care? At our recent Legislative Day in Lansing, one legislator commented to a member from Macomb County, "We hear more from the DOs and chiropractors than from MDs." We can't let this happen!

Auxilians need to be more informed, speak out

Auxilians need to be more informed. We must feel that our opinions count. We must speak out on the issues pro or con, right or wrong. We must speak out. We have installed a phone bank for a Legislative Alert across the state. When you are called, get on that phone immediately and contact your legislator.

One special problem which our legislators need to understand is the need to keep residents and medical students from Michigan here in the state. Too many of them are finding practice opportunities out of the state because the liability climate is not healthy. Legislators should be

Continued on page 426



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AUXILIARY/Continued

sympathetic to this issue. Why should the state pay for the expensive education of these young people, only to lose them to a state more enlightened in regard to tort reform?

And now we come to health. There are many contestants for the dubious honor of Public Health Enemy Number One, but the front runner is AIDS. One cannot open a newspaper, watch television, or talk to people without the subject of AIDS coming up. After the stories in *Cosmopolitan* and the Masters and Johnson book, the public is more confused about AIDS than ever before. It is up to physicians to take a positive stand. Physicians are the ones who have to care for these people. They know the problems involved. Physicians in California, Wisconsin, Massachusetts, and now Oregon, have voiced opposition to informed consent statutes which limit their ability to conduct HIV testing. The AMA and MSMS are trying to cope with this tremendous problem. Never before has it been so vitally essential for so many auxiliaries to join together in a united front to combat this horrible disease. This year, I have appointed an ad hoc committee of two members to keep us informed on this issue.

Drug problem a key concern

The one facet of the AIDS situation which is almost unsolv-

able is the drug problem. And that is my special interest this year—drugs and youth. We seem to be taking two steps forward and three backward. How can we deal with this problem? Education? Yes! It is sad to think how young we have to start educating our children in so many things these days—sex, incest, abuse, rape, AIDS, drugs, smoking. It seems that we are taking childhood away from our children. How can we fight this horrible problem when only recently an Ottawa County sheriff was arrested for allegedly dealing in cocaine?

At a State Board meeting a year ago, I heard a talk given by John Lanzatta, assistant principal at Okemos High School, about the drug problem in their school. The school authorities have been successful in getting the full cooperation of parents and staff in dealing with this problem and their efforts have been met with considerable success. We need more of these programs and the key is the full cooperation of the parents.

Past Auxiliary President Pat Allen recently returned from a White House Conference on Substance Abuse. I shall not repeat her comments except to say that a resolution is being sent to the AMAA, stating in part that "the State and County auxiliaries (should be) encouraged to continue and revitalize programs and projects to promote drug awareness, education, and prevention." I hope to have the benefit of Pat's

expertise on this issue during the coming year.

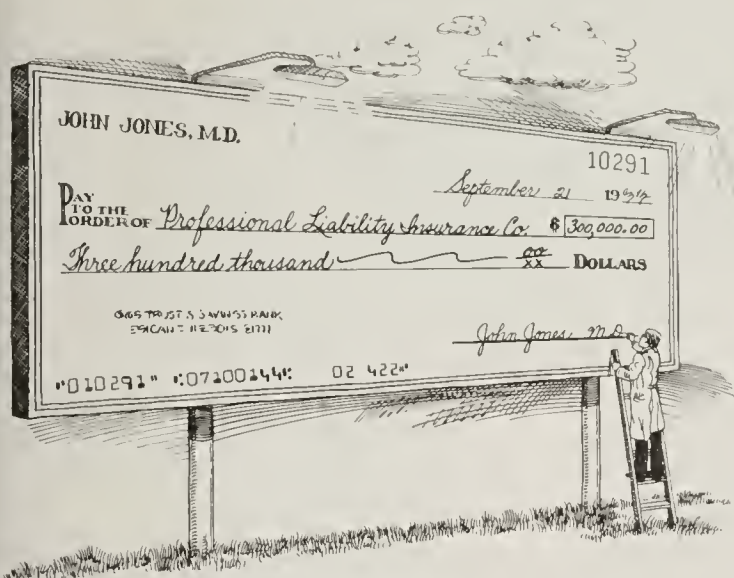
We need strict laws punishing offenders and honest people dealing with these situations.

More members needed

And now we come back to auxiliary—what can we do? Past leaders of the auxiliary already have accomplished much, but we cannot rest on their laurels. We must get new members. We must become more active in legislative actions, and produce more programs in the fields of health and education and AMA-ERF.

Across the country, auxiliaries have set up numerous meaningful programs. One has only to look at the *Project Bank Catalog*, published by the AMAA and available to all members, to appreciate the quantity and quality of ongoing programs. Betty Szewczyk, AMAA president, has asked that all states have at least one program that will help solve the problems of youth. As you go back to your counties, see what can be done either alone or in coalition with other groups.

Confucius taught us that the true guide keeps his eye on the path of the future. As we auxiliaries work together to move into a better future, we must keep our eyes steadily fixed on the path. I am a firm believer that faith can work miracles. So now I ask of each and every auxiliary to think what we can do, at the county level, at the state level, at the national level! □



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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

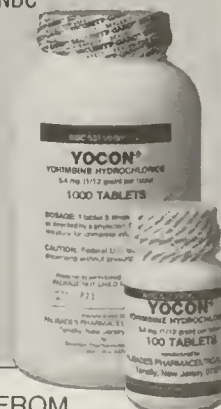
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The way back

By Thomas J. Dekornfeld, MD

The topic hiding under this seemingly simple title is both large and very complex. What I wish to address under this heading are the problems which physicians encounter when they wish to regain their license or have Board-imposed limitations removed.

If the Board imposes a suspension of more than six months, or if the license is revoked, the former licensee must apply to the Board for reinstatement. This can be done within ninety days from the end of the suspension period or after three years from the effective date of the revocation. In the application, the applicant must show by "clear and convincing" evidence that he/she is of good moral character, is capable of practicing medicine safely and effectively and that it is in the public interest that the license be reinstated.

If the Attorney General does not oppose the application, the Board may either grant or deny reinstatement of the license. If the Board denies the application, the applicant may request a hearing. If the Attorney General, as the original complaining party, opposes the application (and he usually does), the applicant may file a request for a hearing within 20 days. This hearing is held before an administrative law judge. The physician may, and usually will, be represented by

counsel and may bring witnesses to testify on his/her behalf. The hearing officer will then file with the Board a "findings of fact and conclusions of law" in which the hearing officer indicates whether, in his opinion, the physician has met the three criteria required for reinstatement. This opinion, together with the transcript of the



hearing, will be before the Board at the next meeting. The Board then decides whether to grant the petition for reinstatement or not to grant it. If the Board turns the petition down, the applicant may not reapply in less than one year from the time of the Board's denial.

It must be obvious by now that getting a license back is not easy.

It is difficult to prove that you are of good moral character, particularly if the license was suspended for a violation of the code which clearly could be construed into moral turpitude. Secondly, it is not easy to prove that one is

capable of practicing safely and effectively, particularly if the sanction was imposed for incompetence, or for an offense which was related to the practice of medicine. The societal need issue is relatively easy; but even there, there may be differences. There may be a much greater societal need for a general internist or family physician in a rural area of the State than for a general surgeon in Ann Arbor.

The Board has very carefully and very prudently avoided giving any specific suggestions as to how moral character or competence or societal desirability can be documented. Nevertheless, certain principles should be clear to all. Good moral character cannot be documented by testimonials from friends, relatives or spiritual advisors. Once moral character is lost, its recovery inevitably will take time, will require contrition and some attempt to atone for the transgression. How much and in what form must depend on the original violation and may vary widely from instance to instance.

To prove that one can practice safely and competently also is not easy. In fact, the Board has the authority to require a mental and physical evaluation and may also require additional education, supervised practice, or severe limits on the reinstated license.

Certainly, any physician who was kept from practicing for any length of time would be well-advised to engage in considerable

Continued on page 430

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DeKORNFELD/Continued

continuing medical education during the period of suspension or revocation.

Doing volunteer work in a medically-related area also may be helpful in showing determination to keep up. There are no rigid guidelines, nor can there be any. It is up to the individual former licensee to devise a way to convince the Board that it would be safe to reinstate the license.

As I had indicated earlier, proving a societal need is relatively easy. If the former licensee can show that he/she has a definite job or position to return to, if colleagues are willing to testify that there is indeed a need for the services or if it is obvious that the former licensee has skills which are not generally available, this requirement for reinstatement should present few, if any, problems.

If the Board grants the petition and reinstates the license, there usually are some conditions attached. There usually is a period of probation during which the licensee may have to report periodically to a representative of the Board. There may be a limit imposed on the reinstated license. This limit may involve a ban on prescribing narcotics, or on performing surgery. The probationary conditions may require attendance at AA or NA meetings, periodic urine or blood samples, or any such matters as the Board may feel are in the best interests of both the public and the li-

censee.

The "way back" is not an easy one. It is long, tortuous and expensive. It is far more prudent and a great deal less expensive to avoid a sanction and to practice medicine honestly and well.

For those interested, the appropriate sections of the Public Health Code and the Administrative Rules are: 333.16245, 333.16247, 333.16249 and R 333.986 through R 338.990. □

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Mediation: An effective tool for resolving some medical malpractice cases

Introduction

Mediation is a procedure designed to settle civil lawsuits prior to trial. The procedure has been operating in Michigan for years. For physicians, mediation can be "a significant pretrial tool in efficiently and economically resolving some medical malpractice cases," according to MSMS Legal Counsel Richard D. Weber. "Proper use of mediation should reduce personal exposure of physicians, save money for insurers, and ultimately result in stabilizing or reducing insurance premiums," he says.

The purpose of this **Physician's File** then is to fully explain the mediation process and to show what a significant role mediation can play in resolving medical malpractice cases. Included in this **Physician's File** are: (1) an article by MSMS Board Chairman Frank B. Walker, MD, on recent MSMS efforts to identify and recruit interested physicians to serve on local medical malpractice mediation panels; and (2) a comprehensive explanation of mediation, written by MSMS Legal Counsel Richard D. Weber.

MSMS needs physicians to serve on mediation panels

By Frank B. Walker, MD
Chairman, MSMS Board of Directors

MSMS is working with component and specialty societies to identify physicians willing to serve on local medical malpractice mediation panels. These panels, to be operated by circuit courts, were established by 1986 tort reform legislation. MSMS is urgently requesting component societies to develop lists of physicians willing to serve as mediators and to send the lists to the circuit court administrators in their areas. (A complete list of circuit court administrators is available upon request at MSMS.) MSMS also is requesting specialty societies to develop lists and to send them to Richard Campau at MSMS for dissemination to the appropriate circuit courts. Physicians interested in serving as mediators should contact their county society office or MSMS headquarters **before July 31**.

The county society lists should contain as many names and represent as many specialties as possible. They should not differentiate between plaintiff and defendant physician mediators, but simply state physicians' names, addresses and specialties. Solicitation of physicians to serve is underway now that the Michigan Supreme Court has promulgated rules to implement the mediation process.

Essentially, these rules require that:

- 1** All malpractice cases, with rare exceptions, are to be mediated.
- 2** The mediation panels will consist of three attorneys and two health care professionals. One health care professional is to be designated by the plaintiff and one by the defendant. They must practice in the same field as the defendant.
- 3** The mediation panel must include a specific finding on the applicable standard of care. The Supreme Court has defined this to mean that the evaluation must include a specific finding of one of the following.
 - a** A breach of the applicable standard of care.
 - b** No breach of the applicable standard of care; or
 - c** Reasonable minds could differ as to whether there has been a breach of the applicable standard of care.



4 If the case is found to be meritorious, the mediation panel will render a written monetary evaluation as to how the trier of fact — judge or jury — would ultimately resolve the case.

A complete copy of the Supreme Court rules are available upon request at MSMS.

5 In the event that the parties do not accept the mediated settlement and a trial ensues, the mediators cannot be called as witnesses.

A comprehensive description of the mediation system, written by MSMS legal counsel, follows:

Mediation

By Richard D. Weber
MSMS Legal Counsel

Mediation is a procedure designed to settle civil lawsuits prior to trial. The procedure has been operating in Michigan for years. The 1986 Tort Reform Legislation established multiple changes in substantive and procedural law in Michigan. One of these changes related to the mediation of medical malpractice cases. Act 178 of the Public Acts of 1986 mandated the changes. By Order entered October 23, 1987, the Michigan Supreme Court promulgated amendments to Michigan Court Rule 2.403, effective January 1, 1988, applicable to mediation. A review of this court rule is necessary for a complete understanding of the mediation process. The court rule, however, is complex. This paper is designed to summarize the mediation system for physicians, highlight the changes relative to medical malpractice cases and comment on the concerns expressed by the medical malpractice mediation committee appointed by the Supreme Court and the challenge to the medical profession.

General Explanation of Mediation:

Parties are required to submit pertinent documents pertaining to the issues along with a concise summary of their respective factual and legal positions. Impartial mediators review this documentation and hear oral presentations from the attorneys. Presentations may be limited to 15 minutes per side, unless unusual circumstances warrant additional time. The mediators render a written monetary evaluation based upon their judgment as to how the trier of fact, judge or jury, would ultimately resolve the case. Mediators must render the evaluation within 14 days after the hearing, but generally make their determination and submit the evaluation to the attorneys immediately following the hearing. Mediation is not binding and the results are not admissible in evidence or otherwise made known to the jury.

If all parties accept the mediation award, the case is settled. If one or more parties reject the mediation award, sanctions may be imposed, unless the award is not unanimous. A party who rejects the award must pay the opposing party's actual costs and attorney fees unless the verdict is more favorable to the rejecting party than the mediation award. If the opposing party has also rejected the award, a party is entitled to costs only if the ultimate verdict is more favorable to that party than the mediation evaluation. A verdict is considered "more favorable" to a defendant if it is more than 10 percent below the evaluation, and is considered "more favorable" to the plaintiff if it is more than 10 percent above the evaluation. If the evaluation was zero, a verdict of no cause for action is deemed more favorable to the defendant. The costs and attorney fees awarded can be substantial. This induces litigants to accept mediation awards with the consequent effect of settling cases. It is significant that no sanctions can be awarded, however, unless the mediation award is unanimous.

Changes Relative to Medical Malpractice Cases:

The statute and court rule mandate five substantive changes to mediation relative to medical malpractice cases filed after January 1, 1987. These changes are summarized as follows:

1 All cases are required to be mediated unless the court, for good cause, determines that mediation of a particular action would be inappropriate. It is unlikely that any court will exclude a medical malpractice case from mediation.

2 Two health care professionals are included on each mediation panel, in addition to three attorneys. Prior to the changes, mediation panels were composed of three attorneys. The attorneys are appointed through the mediation administrative process. Each party appoints a health care professional. The designated health care professionals must practice in the same or a related relevant field as the defendant. If there are multiple defendants in multiple specialties, the designated health professional mediators need only practice in the same or related relevant field as one of the defendants. Failure of a party to timely designate a health care professional, or failure of a health care professional to appear at the hearing, is not grounds for adjournment and the mediation proceeds with fewer than five mediators. Where there is more than one party on the same side, they must agree on the designated health care professional mediator or they are deemed to have waived their right to designate a member.

3 The mediation panel must include a specific finding on the applicable standard of care. The Supreme Court has defined this to mean that the evaluation must include a specific finding of one of the following:

- a there has been a breach of the applicable standard of care;
- b there has not been a breach of the applicable standard of care; or
- c reasonable minds could differ as to whether there has been a breach of the applicable standard of care.

4 If the mediation panel unanimously finds that a party's action or defense is "frivolous," that party must post a \$5,000 cost bond in order to proceed to trial. An action or defense is frivolous if, as to all of a plaintiff's claims against another party or all of a defendant's liability defenses against another party, at least one of the following conditions is met:

- a the party's primary purpose in initiating the action or asserting the defense was to harass, embarrass, or injure the opposing party.
- b The party had no reasonable basis to believe that the facts underlying that party's legal position were in fact true.
- c The party's legal position was devoid of arguable legal merit.

If the bond is not filed within the prescribed time, the court must dismiss a plaintiff's claim found to be frivolous, or enter a default against the defendant whose defense was found to be frivolous. In the event a defense is found to be frivolous, an insurance company that insures the defendant physician may not act as the surety.

5 No mediator may be called as a witness at trial. This precludes any party from using a physician mediator as an expert witness.

What Role Does Mediation Play In Resolving Medical Malpractice Cases?

"Mediation can be a significant pretrial tool in efficiently and economically resolving some medical malpractice cases. Proper use of mediation should reduce personal exposure of physicians, save money for insurers, and ultimately result in stabilizing or reducing insurance premiums."

— Richard D. Weber
MSMS legal counsel



Report of the Medical Malpractice Mediation Committee:

The Supreme Court appointed a medical malpractice mediation committee. This committee was composed of practicing attorneys, judges, and two well-qualified physicians. The committee's report to the Supreme Court was extremely critical of the provision in the tort reform statute that requires inclusion of health care professionals on mediation panels. The committee's conclusion was that the legislation is neither desirable nor practical. The committee specifically expressed its concern that the presence of health care professionals will undermine the mediation process. The basis of the committee's concern is that the credibility and confidence of the system will be adversely affected. Since each party appoints a health care professional mediator, these mediators would be associated too closely with the parties. More specifically, the committee expressed the concern that health care professionals will tend to dissent from awards they view as unfair to "their" party which will result in non-unanimous awards. Since non-unanimous awards carry no sanctions, the likelihood of acceptance would be reduced with the resultant reduction of settlements.

The committee expressed a further concern that it may be extremely difficult for plaintiffs to secure the services of health care professionals as mediators.

The committee also found procedural problems and emphasized the anticipated difficulty in obtaining cooperation from physicians in serving as mediators. One practical concern is that the physician mediators, unlike the attorney mediators, will probably only participate in one case on a particular day (although not necessarily in larger counties) and the fees are not commensurate to the time required to perform this function. Each party to a medical malpractice case must submit \$125.00 to the mediation clerk. This means that cases involving only two parties will result in \$50

being paid to each mediator. More compensation would be available in multiple party cases. Parties are specifically precluded from making any other payment of fees or expenses to a mediator.

Challenge to the Medical Profession

The concerns expressed by the medical malpractice mediation committee are real. The fact that the statute mandates that each party appoint a health professional mediator does impose an element of perceived one-sidedness. It would have been better had the legislature provided for the appointment of physician mediators through the administrative process, in the same fashion that attorneys are appointed. Moreover, the small compensation to be paid to mediators for a single case will require commitment and sacrifice from physicians. The medical profession has a clear challenge to meet these concerns. The committee's report to the Supreme Court suggested that the system be re-evaluated after careful monitoring over a limited period of time. It is likely that such a re-evaluation will occur. When it does, the medical profession must be in a position to refute the anticipated assertions that physicians fail to cooperate and the new legislation frustrates mediation.

MSMS intends to work with the component and specialty societies in the development of a list of physicians willing to participate in their local mediation systems. These lists should not differentiate between plaintiff and defendant physician mediators. They should simply include the physician's name, address and specialty. The list should be provided to the local circuit court mediation administrators. The administrators can then make these lists known to the attorneys and litigants for selection. The ultimate success of the new system will then be left to the effort and cooperation of the individual physicians selected as mediators.

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U-M receives \$6.7 mil contract from NIH

Researchers at The University of Michigan have received a joint \$6.7 million contract from the National Institutes of Health (NIH) to form and operate a national kidney registry.

The U-M will join the Urban Institute in Washington, D.C., to develop a central clearinghouse for information on all patients in the United States with end-stage kidney disease.

The project will collect, computerize, analyze and disseminate information on patients in the United States with chronic kidney failure and help target the causes and potential prevention of renal diseases.

The large data base will enable researchers and physicians to draw stronger conclusions about trends, prognosis, optional care

and problems in kidney disease.

"The registry will track patients with chronic kidney failure—where the patient's life could not be maintained unless treated with dialysis or transplant," said Friedrich K. Port, MD, professor of internal medicine at the U-M Medical Center and chief of the hemodialysis unit at the Veterans Administration Medical Center in Ann Arbor. Doctor Port is deputy director of the registry, called the National ESRD (end-stage renal disease) Data System.

Doctor Port said it would take up to two years to fully establish the national registry. The research will be assisted by a national advisory committee that will help target priorities and research angles. The NIH and the Health Care Finance Administration will be participants in the project. Research at the national kidney registry will complement the \$4 million kidney and urologic center grant awarded by NIH to the U-M in 1987.

Detroit-Macomb Hospital joins United Health

Detroit-Macomb Hospital Corporation (DMHC) has purchased stock of United Health System Inc., joining Beaumont, Oakwood, Providence and Saint John hospitals as a shareholder in this major provider of health care in Southeast Michigan. This purchase was announced in May by Jack Ryan, MD, FACPE, president and chief executive officer

of UHS.

The UHS health care consortium engages in managing and marketing alternative delivery systems. It currently operates Preferred Provider Organization (PPO)—SelectCare VersaMed and a Health Maintenance Organization (HMO)—SelectCare MedExtend.

Patients needed for study

Klugh Clinical Research Center, University Hospital, Ann Arbor, is seeking patients for the study, "Experimental Therapy of High-Grade Refractory Lymphomas Using Monoclonal Antibodies Conjugated to 131-Iodine."

The Center has recently begun a new clinical protocol for patients with low, intermediate, or high-grade lymphoma refractory to standard therapy.

"We are using a conjugated to 131-Iodine (I-131)," says Irving H. Fox, MD, U-M professor of internal medicine and biological chemistry.

"Patients must have a peripheral lymph node that we can biopsy to demonstrate that it is reactive with the MBI antibody prior to entering the trial."

In addition, Doctor Fox says patients must meet the following requirements: (1) have a good performance status; (2) be over 18 years of age; (3) be off all chemotherapy and radiation

Continued on page 444



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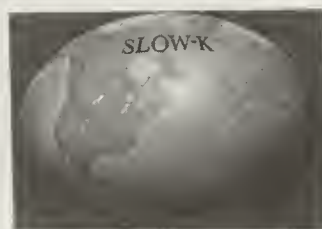
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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al. Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR. Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE)

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

- To take each dose without crushing, chewing, or sucking the tablets.
- To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
- To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
- To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

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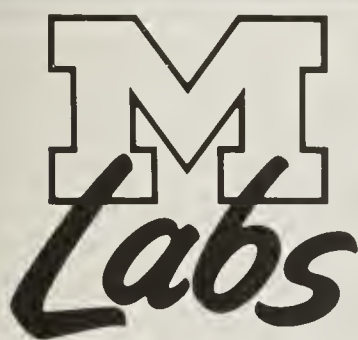
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MSMS speaker **Robert D. Burton, MD** has been awarded the Distinguished Service Award for his outstanding contribution to public health, primarily in Michigan. In addition to his distinguished medical career in Michigan, Doctor Burton has served as chairman of the Coalition for Safety Belt Legislation, chairman of the Coalition for Safety Belt Use, and has been a member of the Executive Council, Governor's Conference on Traffic Safety.... **Thomas E. Berglund, MD**, Kalamazoo, has been named president and chairman of the board of Michigan Physicians Mutual Liability Co. (MPMLC), the state's only physician-owned medical malpractice insurer. **John W. Hall, MD**, a urologist at the Burns Clinic Medical Center, Petoskey, and clinical instructor of the University of Michigan's Department of Surgery, was elected to the board of directors of MPMLC at the company's annual meeting in May.... **William Decker, MD**, Kalamazoo, has been appointed chief of psychiatry service at the Veterans Administration Medical Center in Battle Creek.... **Jack Ryan, MD, FACPE**, Detroit, president and chief executive of-

U-M physician treats patient with cold nose, pointy ears

It's not unusual for **Albert P. Rocchini, MD**, a University of Michigan pediatric cardiologist, to be consulted on the treatment of a patient elsewhere in the state.

It is unusual when the patient is an English bulldog puppy.

Doctor Rocchini recently answered a call for help from veterinarians at Michigan State University by teaching them how to use angioplasty to help dogs with blocked pulmonary arteries.

Rocchini, an associate professor of pediatrics at the U-M Medical School, for several years has been using angioplasty to treat dogs with the same condition in research projects in order to develop and improve the technique

for use in humans.

"The veterinary cardiologists had, up until now, done surgery on the dogs, and were interested in doing angioplasty instead of surgery," he explains. "I had a lot of experience with dogs, so I volunteered to help them."

"It's the first time I've ever done something like this."

Rocchini says he enjoyed his experience at the MSU veterinary clinic, which treats animals referred by vets throughout Michigan. "It's the first time I've ever done something like this," he says, adding, "I think it's great that during a time when animal rights advocates are so against experimentation using animals, that some of this experimentation comes back to help the animals. □"



Hall

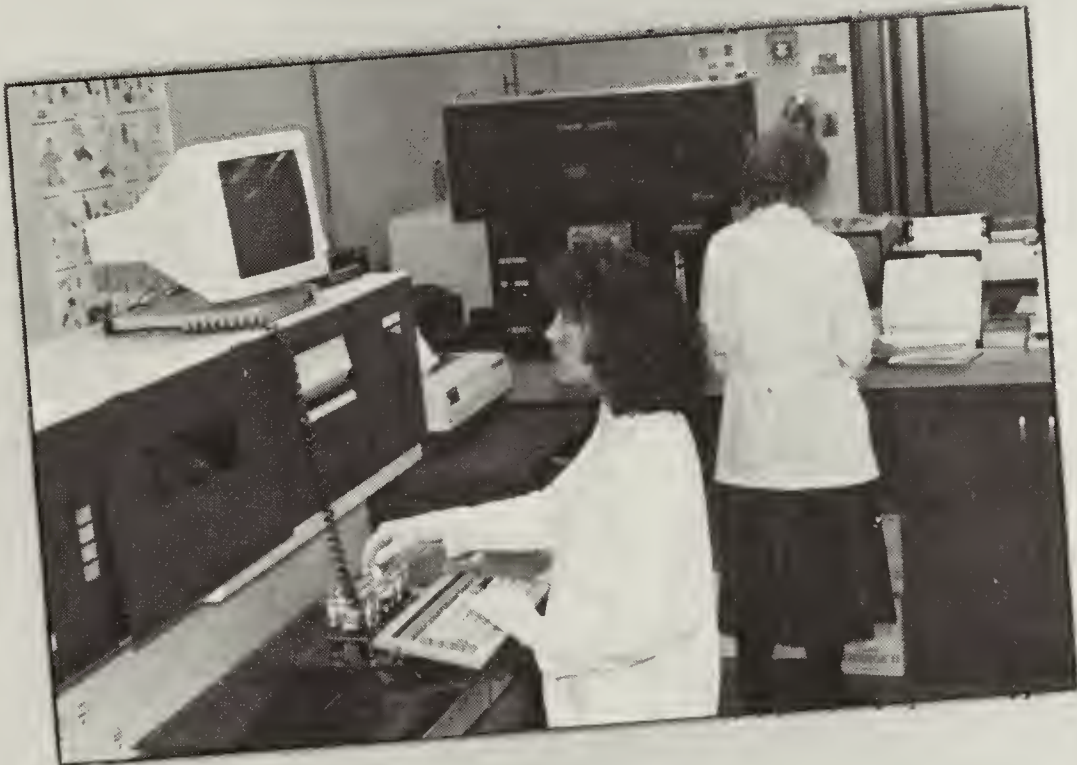


Ryan

ficier, Detroit-Macomb Hospital Corporation, was elected to the board of directors of the American Academy of Medical Directors during its 13th National Con-

ference on Health Care Leadership and Management in California. Doctor Ryan has been a member of the Academy since 1977 and will serve on its Board for three years.... **Charles Schmitter, Jr., MD**, Ann Arbor, has been named president of the Michigan Society of Anesthesiologists. **Georgine Steude, MD**, also of Ann Arbor, is the new president-elect, and **Bert Bez, DO**, is the new secretary-treasurer. □

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NEWSFRONTS/Continued

therapy for four weeks; (4) have measurable disease; and (5) preferably have minimum bone marrow involvement.

An ongoing study at a different institution with a different B-cell monoclonal antibody conjugated to I-131 has demonstrated dramatic responses (including complete response) in several patients with non-Hodgkin's lymphoma. All of the patients have failed standard chemotherapy. "We are encouraged by these results and

are hopeful that our study will be equally effective," Doctor Fox said.

For further information, contact: Mark S. Kaminski, MD, assistant professor of internal medicine, Division of Hematology/Oncology, director, Leukemia/Lymphoma Program, University of Michigan Cancer Center, (313) 936-5290; or Richard L. Wahl, MD, associate professor of internal medicine and radiology, director, general nuclear imaging, Division of Nuclear Medicine, (313) 936-5384.

Age, sex, education affect health habits, U-M study shows

Seatbelt use is going up and smoking continues to decline as America moves towards the end of the health-conscious 80s, affirms a new study from The University of Michigan Fitness Research Center (FRC).

But the patterns for these and other health behaviors can't be generalized across the population, FRC researchers say. Age, sex and education must all be considered in any account of the country's progress in meeting the U.S. Department of Health and Human Services 1990 objectives for the nation.

The FRC data came from 200,000 Health Risk Appraisals administered at worksites across the nation during 1980-1987. The 93,524 males and 110,279 females were studied in age groups of 18-29; 30-44; 45-64, and 65-75. Forty-five percent were college graduates.

Education appears to have the most consistent influence, according to study authors Marilyn Pearce Edington, Louis Yen and D.W. Edington.

"In areas ranging from non-smoking and weight control to knowledge of blood pressure and cholesterol levels, the higher one's education level, the better their health habits," they report.

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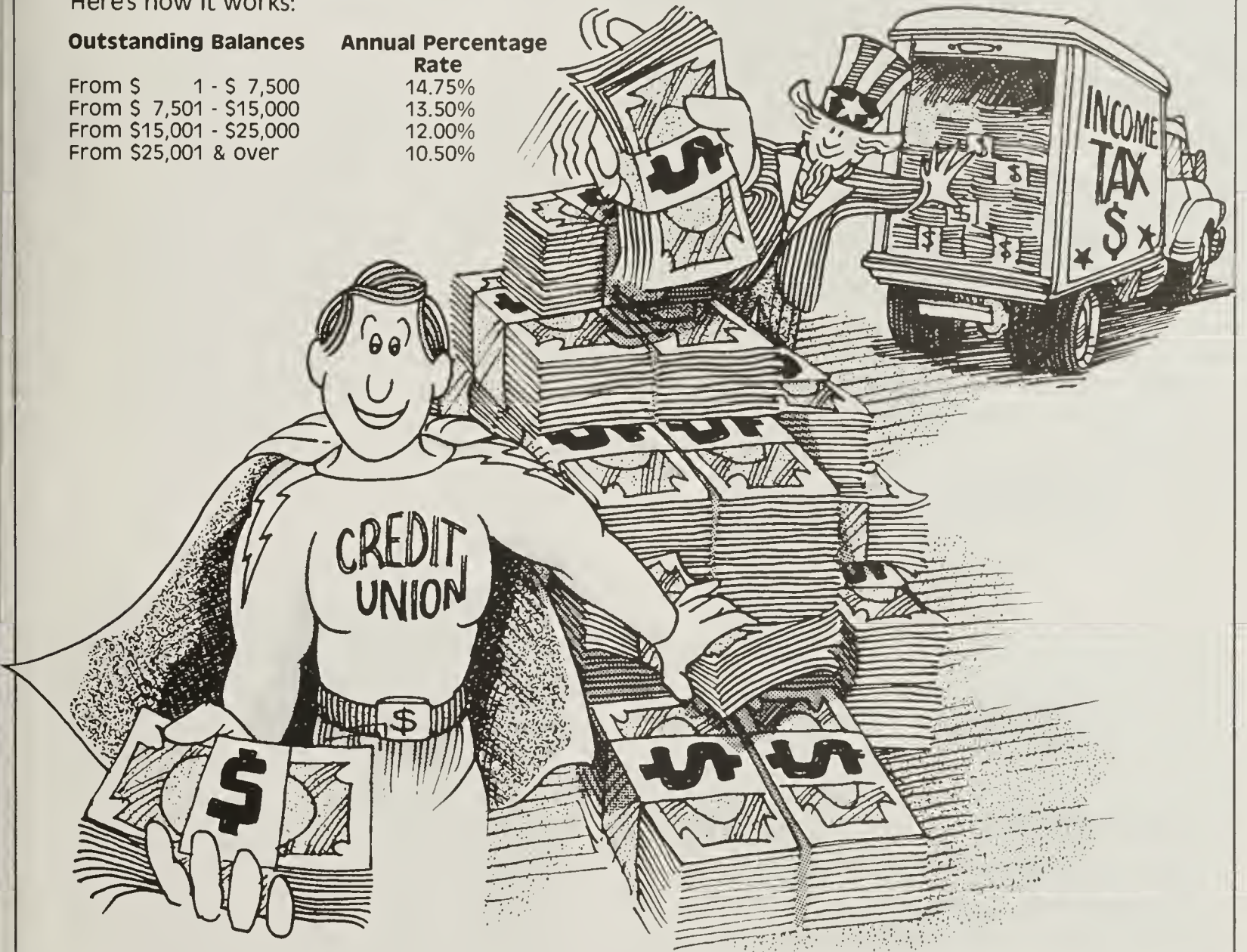
Continued on page 446

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NEWSFRONTS/Continued

Older is correlated with wiser when it comes to knowing blood pressure and cholesterol levels, the study showed. Sixty-two percent of the men and 59 percent of the women reported knowing their blood pressure. In both cases, the older age groups were more likely to know these values. A similar pattern occurred for the 29 percent of the men and 25 percent of the women who knew their cholesterol levels.

Although younger people in the study were less likely to know their blood pressure and cholesterol levels in the lower ranges (blood pressure: less than 140/90; cholesterol: less than 200 mg/dl).

One of the 1990 objectives is that 75 percent of the population will be non-smokers. Male college graduates across all age groups in the FRC study have met this objective, while male non-college graduates 18-64 are below it. All women's groups in the FRC sample are above the 1990 objectives

aim for 90 percent of adult males and 83 percent of females to be within 120 percent of their ideal weight by 1990.

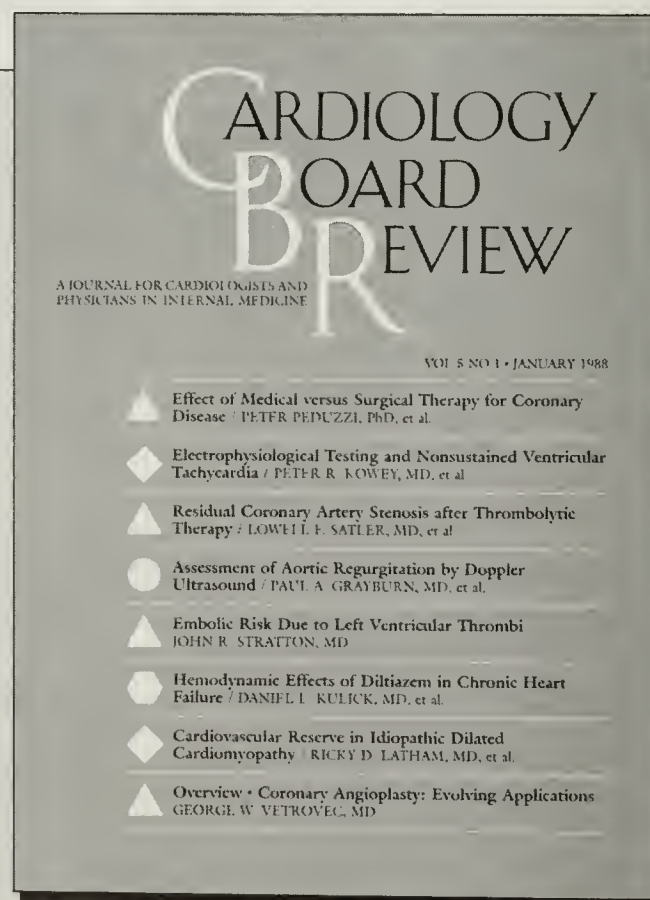
The study indicates that Health Risk Appraisal group summaries can be useful in projecting U.S. health trends, the FRC researchers conclude.

However, the data should be viewed in age, sex and education-level groupings to assure accurate assessments. □

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CARDIOLOGY BOARD REVIEW
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* Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

SWANSON/Continued

\$100,000 with their future and life insurance as collateral, and face costs of \$75,000 to \$100,000 to start a private practice, while having to pay another \$10,000 to \$75,000 per year for a mere \$200,000 malpractice insurance coverage that provides no liability protection for the family's savings or retirement benefits?

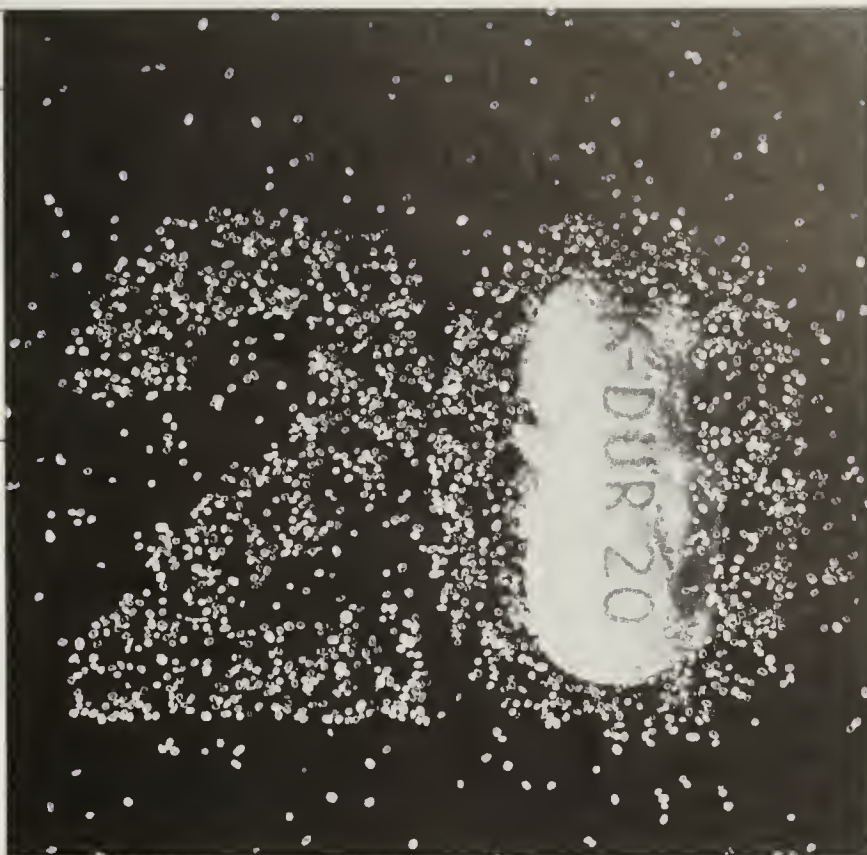
Why, in spite of this commitment, and in our field an average investment of 13 intensive years of post high school training, and onto a demanding and exhausting practice of their profession, doesn't the public understand or appreciate these most dedicated citizens, many of whom get forced into early retirement because of the high cost of malpractice insurance. Should the voice of an elder physician or the surgery of a master surgeon be available, if he can only work part-time? Liability insurance plans demand full-time labor or nothing. Is that fair?

Work isn't enough to command respect?

Our nation's doctors are wondering why their work is not enough to command the respect of the public legislatures and social scientists, many of whom are planning to nationalize the system of medical delivery based on the faulted British and Swedish socialized medicine plans. They state that this is the only way to restrict ever increasing medical costs. These foreign systems, where a patient must be wait-listed for five to eight years for repair of an arthritic hip or disabled hand, do not compare with the system that we now have.

Why is American Medicine at the crossroads when it is the most available and of the highest quality in the world? Is it really pricing itself out of the world? Is it really pricing itself out of the market? Is it because of ever increasing Draconian government rules and regulations, conflicts between hospitals, HMOs, PPOs, DRGs, MACC levels and proprietary medical centers who work against rather than with physicians? Is it because of patients with a liability mind-set who demand perfect results and twist an out-of-date tort system

Continued on next page



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Please see next page for brief summary of prescribing information.

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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium-Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS**.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS and WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS and WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.

3. Correction of acidosis, if present, with intravenous sodium bicarbonate.

4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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SWANSON/Continued

with the help of avaricious plaintiff's attorneys and activist judges? Is it because new methods are enormously expensive and must be rationed? Is it because some doctors have become business marketers and entrepreneurs, and have forgotten their Hippocratic Oath and appear to give an image of golf playing, Mercedes driving, high charging specialists who really don't care any more about fair fees, free medical clinics and poor people? Is it because legislators and social scientists are really in control?

"As a line from the comic strip Pogo states, 'We have met the enemy and he is us.'"

Can doctors rationalize and blame others for all of these happenings? Not at all! As a line from the comic strip Pogo states, "We have met the enemy and he is us."

Should hard, honest and ethical work in America result in a successful and peaceful life. Not So! America demands participation in the process by those who are affected. Thomas Jefferson's statement, "the price of liberty is eternal vigilance," holds today. The price of fairness in America is to demand it, to work for it, and to win. With every freedom comes the responsibility to preserve it. Doctors have to wake up to what's happening around them.

I counsel my residents about four responsibilities in life: 1) to yourself—be the best you can be; 2) to your family—give quality time, concern, love and support; 3) to your profession—give back what you have received; and 4) to your

Continued on page 451

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SWANSON/Continued

environment and your community — conserve it and make it better by becoming involved. The latter is most frequently ignored by busy professionals.

Only 10 percent of the doctors helped the Citizens Liability Action Committee efforts in 1976 and 1986 in its petition drive for a citizens' initiative to change the laws at fault in the liability crisis. In 1986, we obtained 270,000 signatures and needed 304,001! If five percent more doctors would have helped, we would have easily won! Where were they?

Why are doctors in trouble? It is because not enough stand up to be counted in joining the citizen and political requirements needed to change and alter the system when it needs it. "Let George do it!" "I am apolitical!" "I can't or don't care to get involved!" These are common positions taken by doctors.

It is time to throw out the money changers from the temple. You must use your inalienable rights as citizens to improve the system for yourself and your children. You must demand of your hospitals, your societies and their committees, and of your governmental representatives, to represent your progressive ideas. Give of yourself, your time and our funds. You must fight, not quit and run, not retire and fade away. Stand up to be remembered!

Doctors are always rated at or near the top in national polls for

the "most respected." They must use this respect to garner support for the necessary changes to provide adequate quality medical care for all Americans in a way consistent with the American Way. They must dedicate themselves, and all their skills and knowledge, to confidently develop and promote an ideal med-

"A critical mass of actively concerned physicians can get the public, government and business support needed to correct the course of medicine."

ical delivery system, if given a chance.

The people need to know more about the doctor's life struggle and how it benefits their medical care. We have a vital profession that deals with birth and death, and all the in-between crises. A critical mass of actively concerned physicians can get the public, government and business support needed to correct the course of medicine. The people and the profession need to be treated fairly. Time is of the essence! If you do not think so, have you visited England lately? □

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

July

21-24, Fifteenth Michigan Emergency Medicine Assembly: EMS Concepts 88 and Base Station Symposium. Location: Hilton Shanty Creek, Bellaire. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 22 hours Category I Credit.

21-24, Ocular Surgery Update: Newest Techniques, Complications and Management of Ocular Tumors. Location: Grand Hotel, Mackinac Island. Sponsor: Michigan Ophthalmological Society. Contact: Christine Jourdain, 412 Eastland Professional Bldg., Harper Woods 48225 (313)839-0311. Approved for: 8 hours Category I Credit.

24-27, 2nd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 13 hours Category I Credit.

25, 42nd Annual Scientific Assembly. Location: Grand Traverse Resort, Acme. Sponsor: Michigan Academy of Family Physicians. Contact: Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151. Approved for: 25.5 hours Category I Credit.

28-29, Collier Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. Sponsor: Munson Medical Center. Contact: Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City 486842386 (616)922-9546. Approved for: 13 hours Category I Credit.

August

1-6, Pediatric Board Review. Location:

Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Association of Pediatric Program Directors. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 53 hours Category I Credit.

7-10, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School 48109-0201 (313)763-1400. Approved for: 11 hours Category I Credit.

19-22, Cardiology Update. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 10 hours Category I Credit.

September

7, Cardiovascular Risk Factors in the Black Population—Special Emphasis on Hypertension. Location: Michigan Inn, Southfield. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 3.75 hours Category I Credit.

15, Effects of Cardiovascular Disease in the Older Patient. Location: Southfield Hilton, Southfield. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 3 hours Category I Credit.

15-16, Neonatal Emergencies. Location: Towsley Center for Continuing Medical

Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Pediatrics and Communicable Diseases, Section of Newborn Services and Pediatric Pulmonary Medicine. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

15-17, 11th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 13 hours Category I Credit.

17, Cytopathology of Breast Lesions. Location: Henry Ford Hospital. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 5.5 hours Category I Credit.

19-20, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

22-24, 19th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan State University College of Human Medicine, The International Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. Contact: Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616)774-0440. Approved for: 18 hours Category I Credit.

Continued on next page

CATEGORY I COURSES/ Continued

26-27, Sexual Exploitation of Persons with Disabilities. Location: Michigan League, 911 North University, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Physical Medicine and Rehabilitation, Kenny Rehabilitation Foundation of Michigan. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

October

1, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 5 hours Category I Credit.

1, AIDS and Primary Care Physicians in Michigan. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 7 hours Category I Credit.

2, Michigan Chapter American Academy of Pediatrics Annual Scientific Meeting. Location: Grand Traverse Resort and Conference Center, Traverse City. Sponsor: Michigan Chapter American Academy of Pediatrics. Contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, MI 48018 (313)553-3646. Approved for: 7 hours Category I Credit.

3-4, Impairment Evaluation and Disability Considerations. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Surgery and Department of Physical Medicine and Rehabilitation. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

3-4, Ear, Nose and Throat Practicum. Loca-

tion: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 17 hours Category I Credit.

4, Critical Clinical Issues in the Care of the Elderly. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 12 hours Category I Credit.

7, Diagnosis and Management of Lymphoma. Location: Henry Ford Hospital. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 6.5 hours Category I Credit.

6-7, Nutritional Support: A Return to Basics and Current Day Management. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Parenteral and Enteral Nutrition Team, Section of Pediatric Surgery, Department of Surgery. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 10 hours Category I Credit.

14-15, 1988 Michigan Statewide Conference on Child Abuse and Neglect: Strategies for Successful Prevention and Treatment. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 11 hours Category I Credit.

17-18, The Dilemma of the Complications of Diabetes. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: Univer-

sity of Michigan Medical School, The Michigan Diabetes Research and Training Center, The Michigan Affiliate of the American Diabetes Association. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 13 hours Category I Credit.

December

4-5, The Difficult Airway. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 12 hours Category I Credit.



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MEETINGS



MSMS MEETINGS

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

October

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517)337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

October

5-6, AMA Seventh Annual Science

Reporters Conference, Westin St. Francis Hotel, San Francisco, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

December

4-7, AMA Interim Meeting, Dallas, Texas, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

July

21, Fifteenth Michigan Emergency Medicine Assembly—EMS Concepts 88 and Base Station Symposium, Michigan Chapter of the American College of Emergency Physicians, Hilton Shanty Creek, Bellaire, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

22-24, Michigan Society of Medical Assistants Summer Seminar, Michigan Society of Medical Assistants, Holiday Inn, Dearborn, contact: Caroline Kimmel, MSMA, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

25, 42nd Annual Scientific Assembly, Michigan Academy of Family Physicians, Grand Traverse Resort, Acme, contact: Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151.

August

19-20, Michigan Society of Thoracic Surgeons Annual Scientific Meeting, Grand Hotel, Mackinac

Island, contact: Luis A. Tomatis, MD, President, 21 Michigan Street, N.E., Suite 550, Grand Rapids 49503 (616)459-6577.

October

2, Michigan Chapter, American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Resort and Conference Center, Traverse City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018 (313)553-3646.

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

NATIONAL SPECIALTY SOCIETIES

August

23-26, The American College of Physician Executives, The American Academy of Medical Directors First Executive Symposium on Health Care Management, Four Seasons Hotel, Vancouver, British Columbia, contact: The American College of Physician Executives, One Urban Centre, 4830 West Kennedy Boulevard, Suite 648, Tampa, FL 33609-2517 (813)287-2000.

September

14-17, American Group Practice Association Annual Meeting, Hotel Intercontinental, San Diego, CA, contact: American Group Practice

Continued on next page

MEETINGS/Continued

Association, 1422 Duke Street, Alexandria, VA 22314 (703)838-0033.

23-24, American Academy of Facial Plastic and Reconstructive Surgery Annual Meeting, Washington, DC, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202)842-4500.

26-29, American College of Emergency Physicians Scientific Meeting, New Orleans Convention Center, New Orleans, LA, contact: American College of Emergency Physicians, P.O. Box 619911, Dallas, TX 75261-9911 (214)550-0911.

October

1-6, American Academy of Family Physicians Annual and Scientific Meetings, New Orleans Marriott, New Orleans, LA, contact: American Academy of Family Physicians, 1740 W 92nd Street, Kansas City, MO 64114 (816)333-9700.

3-7, American College of Chest Physicians Scientific Meeting, Anaheim Hilton, Anaheim, CA, contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068 (312)698-2200.

8-12, American Academy of Ophthalmology Annual Scientific Meeting, Las Vegas, NV, contact: American Academy of Ophthalmology, P.O. Box 7424, 655 Beach, San Francisco, CA 94120 (415)561-8500.

8-12, American Society of Anesthesiologists Annual Meeting, San Francisco Hilton, San Francisco,

CA, contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068 (312)825-5586.

17-19, American College of Gastroenterology Annual Meeting, Hilton, New York, NY, contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944 (617)927-8330.

23-28, American College of Surgeons Annual Meeting, Hilton, Chicago, IL, contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611 (312)664-4050.

26-30, American Academy of Child and Adolescent Psychiatry Annual Meeting, Westin Hotel, Seattle, WA, contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.E., Washington, DC 20016 (202)966-7300.

30-11/4, American Academy of Physical Medicine and Rehabilitation Annual Scientific Meeting, Convention Center, Seattle, WA, contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603 (312)922-9366.

31-11/5, American Academy of Pediatrics Annual Meeting, San Francisco, CA, contact: American Academy of Pediatrics, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007 (312)288-5005.

November

12-16, American College of Allergists Annual Scientific Meeting, Westin Century Plaza, Los Angeles, CA, contact: American College of

Allergists, 800 E. Northwest Highway, Suite 101, Mt. Prospect, IL 60056 (312)255-0380.

December

3-8, American Academy of Dermatology Annual Scientific Meeting, Washington, DC, contact: American Academy of Dermatology, 1567 Maple Avenue, P.O. Box 3116, Evanston, IL 60204-3116 (312)869-3954.

OTHER MEETINGS

September

23, Linking Research and Practice in Nutrition Education, Hannah Ballroom, East Lansing, contact: Dairy Council of Michigan, 1-800-548-8097.

October

14-16, Sepulveda Epilepsy Education Program, Ann Arbor, contact: The Reverend Charles H. Swinehart, Jr., Epilepsy Support Services, 6159 Aldine Drive, Brighton, 48116 (313)229-4193.

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TWO INTERNISTS, one pediatrician, and one general surgeon needed to join busy seven-man multispecialty group in Mid-Michigan. Several physicians ready to retire. First year income guaranteed. Contact: Owosso Medical Group, Owosso, MI 48867 (517)725-2155.

NORTH DAKOTA: 35-physician multispecialty group seeking orthopedic surgeon, unlimited potential, desirable medium size community in large service area. Position carries exceptional first-year income and benefit package. Contact Robert Suleski, 250 Regency Court, Waukesha, WI 53186, 1-800-338-7107 or (414)785-6500 (collect in Wisconsin).

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cal walk-in clinic. Also needed out-patient proctologist willing to do general surgery. Send confidential resume to Belleville Medical Clinic, 265 Main Street, Belleville, MI 48111.

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PEDIATRICS. Young, dynamic pediatric group in southwestern Michigan seeks motivated, well-

trained associate. Large practice with hospital-based clinic and three suburban offices. Subspecialty interests welcomed. University town with many cultural opportunities. Excellent salary and benefit package. Send CV to Box 124, *Michigan Medicine*, P.O. Box 950, East Lansing, 48826-0950.

WISCONSIN Reedsburg, 50 miles outside of Madison, is seeking a third adult psychiatrist. The incoming psychiatrist may establish a private practice with the two current psychiatrists in the community or choose to establish an association with the Madison Psychiatric Associates. Excellent guarantee with benefits. Contact: Jean L. Ecos, 15975 W. National Avenue, New Berlin, WI 52151 (414)784-2777 (collect).

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PSYCHIATRIST WANTED to join a well-established general psychiatry practice. Reply to Box 125, *Michigan Medicine*, P.O. Box 950, East Lansing, 48826-0950.

ORTHOPEDIC SURGEON A progressive 131-bed two hospital system is seeking a Board certified or Board eligible orthopedic surgeon to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital's have a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801 (906)779-4502.

PSYCHIATRIST A progressive 131-bed two hospital system is seeking a Board certified or Board eligible psychiatrist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital's has a medical staff of 45 full-time physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906) 779-4502.

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Continued on next page

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ENT A progressive 131-bed two hospital system is seeking a Board certified or Board eligible otolaryngologist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906) 779-4502.

EMERGENCY ROOM PHYSICIAN Michigan, Upper Peninsula hospital based emergency department located in a resort area with 15,000 visits annually. Immediate opening for one full-time physician. Applicants must be ACLS certified with previous emergency department experience. Competitive salary with malpractice paid and benefits. Excellent hunting, fishing and outdoor recreational area. Interested applicants send CV with home phone number to Dr. Robert J. Trethewey, Dickinson County Memorial Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906) 779-4555.

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GENERAL INTERNIST: Marshfield Clinic, a 260-physician multispecialty group practice, is seeking BE/BC general internal medicine specialists to join its expanding department in Marshfield, Wisconsin. The department is currently staffed by 23 general internists with immediate plans to add seven or more additional members. The current call schedule is generally one night per month and one out of five weekends. An Internal Medicine Residency Program, University of Wisconsin Medical School affiliation, Medical Research Foundation, and ongoing new developments, i.e. Geriatrics Evaluation Center and walk-in medicine contribute to a very stimulating environment. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to \$85,000 with salary in two years up to \$110,000. Fringe benefit package outstanding. Send CV and references to: David L. Draves, Department of Administration, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect (715) 387-5376.

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"Hold it!! . . . Just exactly what did you mean when you said, I probably won't be in the hospital very long after surgery?"

Migrant worker

By Fred W. Bryant, MD

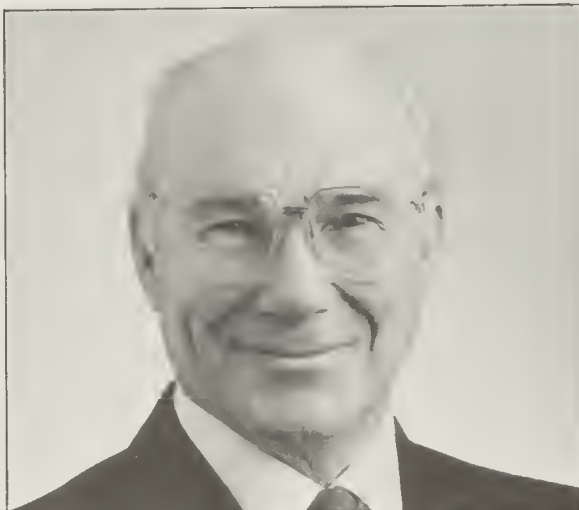
"The president is handmaiden to the interests of the Society, ever-attendant to its activities."

The president is handmaiden to the interests of the Society, ever-attendant to its activities. The gamut of his duties is so broad that he may appear in different form in different light.

The president is circuit rider to the component medical societies, an apostle who goes forth to preach the gospel, a father figure to the faithful. To doubters, he is an evangelist, attracting, converting and recruiting. He may seem a prophet, pointing the path to the future.

To the Auxiliary, he is family. To kindred professions, he is a companion and fellow traveler, extending a hand clasp and smile while sharing wisdom and experience, building and strengthening.

The president is a ceremonial figure, his presence part of the protocol of affairs of state. He is on hand for the recognition of noteworthy accomplishments and to congratulate the worthy. He is witness to the final official acts of retiring officers and the installation of the new. Along with a host of others, he may contribute color and pageantry to im-



Doctor Bryant

portant events, making for a vivid and indelible memory.

More, in a bewildering world of cummerbunds and bow ties, lapel pins and name tags, the president stands out as a sounding board, a visible presence, subject to close scrutiny and query, an immediate source of reference.

The president is at the font of daily information and logic of the Society. He is part of spontaneous conference and unique, formative committees that examine nascent ideas as they bubble to the surface, perhaps eventually to become factors in mainstream medicine.

Visiting fireman and traveling salesman to other states, the president is an informed itinerant and

comparison shopper in other idea markets.

Modern medicine participates in the grand national pasttime, observing and advising how the government should be managed. The subjects include Malpractice and Medicare, maternal health and malnutrition, misuse of medication and the malady AIDS, mental health, the menace of mobile all-terrain vehicles to minors, and migratory flight of medical manpower in response to prohibitive professional liability premiums.

The president is spokesman to his peers, the public, allied professions, the press and political issues. He is a batter in baseball striving to hit for the cycle, trying to touch every base and to advance in every possible way.

The president is a kinetic, hospitable hobo skittering across the face of the state, meandering Michigan and beyond, following where the road leads, sampling the many flavors on the local scene, listening in, observing and gaining from every experience to the benefit of the Society.

From grassroots to headquarters and back again, it's wonderful wandering!

Doctor Bryant is MSMS president.

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Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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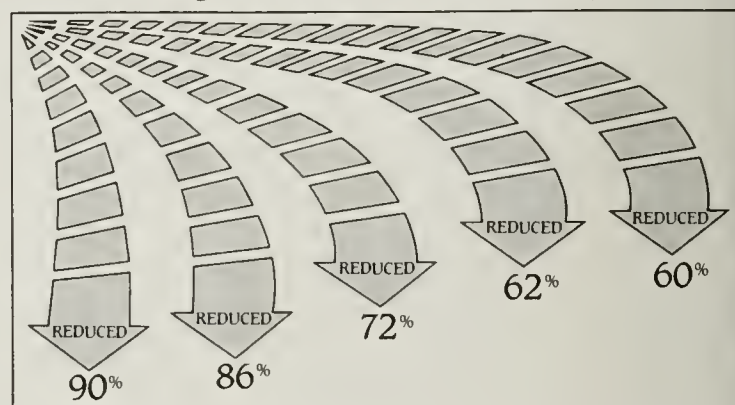
See Improvement In The First Week¹

And The Weeks That Follow

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AUGUST 1988

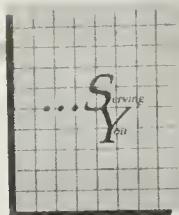
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M I C H I G A N MEDICINE

AUGUST 1988 Vol. 87. No. 8

Special Report

Michigan — and the nation — have continuing problems of attracting physicians to rural areas, and then of keeping them there. The problem in Michigan is exacerbated by the current medical liability insurance crisis. Because the situation has not improved over the past 20 years, state and federal agencies are renewing efforts to find solutions. One state agency proposes a “buy-back” of new physicians’ educational loans, and would like to see a state version of the National Health Service Corps. These are the subjects of the *Michigan Medicine* special report this month, written by MSMS Editor Judy Marr.

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Physician’s File

This third in a series of reference reports for physicians defines arbitration and discusses how it can be used as an alternative to the court/jury system for resolving disputes arising out of health care treatment

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The plight of the family doctor
— By Michael Buenafior, MD

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Frank B. Walker, MD

A new member of the AMA Board of Trustees

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Young physicians conference slated

The MSMS Young Physicians Section, in cooperation with MSMS subsidiary Physician Service Group Inc., is offering a one-day workshop for young physicians

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MSMS addresses the dangers of ATVs

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How to keep your practice competitive

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Nursing shortage: A deepening dilemma

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In next month’s issue of *Michigan Medicine*:
Issues in Adolescent Health Care.

Cover photo by: Michael J. Schimpf

MPRO pre-authorization should be eliminated

By John W. Hall, MD

It always has been difficult to define "unnecessary surgery."

If a patient is willing to face almost certain death, then an operation for a rupturing abdominal aneurysm is unnecessary. It is the patient's choice. It is often impossible to remove a widely metastatic tumor with a surgical procedure. An operation in this situation is unnecessary even if the patient desires it. The surgeons have the choice.

Now there is a third possible type of unnecessary surgery. If a review organization feels that a patient does not meet a set of arbitrary criteria, then the proposed surgery is declared unnecessary even if the physician and the patient feel it is indicated.

Doctor Hall is a member of the MSMS Committee on Publications.



Doctor Hall

As the cost of the Medicare program has grown, it is obvious that the government has promised more than it can afford. In an attempt to control costs, a pre-authorization program was established for certain high volume operative procedures such as transurethral prostatectomy. The Michigan Peer Review Organization was awarded the contract to

perform review. The theory behind this program was that money could be saved by eliminating "unnecessary surgery."

Doctor David Johnson of Lansing obtained the MPRO data on the pre-authorization program for 65- to 70-year-old men requiring a TUR-P. It showed that in 1985-86, 4,854 telephone calls were made to MPRO. The nurse reviewer approved 4,743 or 97.7 percent of these requests. One-hundred-and-eleven calls were referred to a physician who approved an additional 101 patients. At this point 99.8 percent of the requests met the criteria, and surgery proceeded. Obviously, there was no cost savings so far, and 4,743 "unnecessary" telephone calls were made.

One of the ways review organ-

Continued on page 483

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The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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New prescription drug abuse laws

As you may know, the Michigan legislature recently enacted a number of laws which address the problem of prescription drug abuse and diversion. These laws impose many new requirements and represent significant changes to existing statute.

Following is a summary of the legislation which we would encourage you to share with your members and any other interested individuals:

Public Act 250 of 1987 (Effective 6/28/88): Authorizes the Board of Pharmacy to require an applicant or holder of a pharmacy, manufacturer or wholesale distributor license to identify each partner, stockholder, officer or member of the board of directors. Violation of this article may result in reprimand, probation, denial, suspension, revocation or limitation of license, restitution or fine.

Public Act 9 of 1988 (Effective 8/4/88): Requires distributors to report quarterly on all sales of schedule 2 controlled substances. The report must be in writing and include the amount of the controlled substance and name of each licensed practitioner or retail pharmacy to whom the controlled substance was distributed. Penalty for violation of this section is a four-year felony and/or \$30,000 fine.

Continued on page 508

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Rural physicians are facing a variety of problems in the state

By Judy Marr, Editor

In the summer of 1987, Ludington internist Robert Shannon, MD, wrote an apologetic letter to his patients.

He was moving to Ann Arbor, he wrote, and no longer would be able to care for them. He had tried in vain for three years to find a partner to help him shoulder his practice load.

He could not attract a partner, he said, for a number of reasons: "As a rural area, Ludington has sometimes limited access to specialists, new technology, shopping and cultural events." Lower Medicare reimbursement to physicians in rural areas, and the volume of work in the rural area where doctors are scarce, were other discouragements.

He simply could not go on working shorthanded and at such a demanding pace, Doctor Shannon said. He wanted more time with his family. He was joining a group in the southern portion of the state where he would not be so burdened.

Doctor Shannon's letter was heartfelt and dramatic, but it raises some questions.

Was he fairly depicting the plight of rural physicians in Michigan? How bad are things? Have they improved or worsened? What can be done to improve the supply of rural physicians? What, if anything, is being done?

In fact, it appears Doctor Shannon was fairly accurate. Though steps were taken on a federal level years ago to try to bring more physicians to rural



areas, there haven't been many improvements in the situation over the past 20 years.

Because things have not improved, national attention on rural health problems has intensified during 1987 and 1988. The renewed attention has allowed rural physicians to hope for improvements and at least has gained them greater support.

Long-time problem

"...the general impression here seems to be that...things are not better. There still is a significant shortage of rural physicians," says Tom Logan, PhD, vice president of planning for the Grand Rapids-area Alliance for Health.

"Physicians are not flocking to the small hospitals and communities."

Doctor Logan has been active for many years as a health plan-

ner in Michigan.

"Despite the larger numbers of physicians, they are just oversupplying the urban areas as they have for a long time," he continues. "There they are able to offer quality care with support services, to enjoy the collegiality of other physicians, and not be stuck with home visits."

American Medical Association statistics support his observations. They show that in US metropolitan areas one doctor now is available for every 480 patients. In rural American counties of less than 10,000, however, that number is one for every 1,886 patients.

Richard L. Jackson, president, Jackson and Coker, Atlanta, one of the nation's largest physician search firms, reported in the May 1987 issue of *Hospitals* magazine that over 50 percent of all physicians practice in only eight states. Nearly 60 percent of hospitals recently polled by Jackson and

Physicians are scarce in rural Michigan

By Judy Marr, Editor

Coker were looking for physicians. The June 3, 1988 *American Medical News* reported the availability of small-town MDs is currently about one-third that of non-rural MDs. *American Medical News* said there are 57.4 physicians per 100,000 population in rural areas.

The situation could get worse soon, continued the AMA newspaper.

"The number of rural physicians in this country could drop by as much as 25 percent in the next five years," said *American Medical News*.

"Such a decline would exacerbate current shortages of physicians in sparsely populated areas, leaving a significant part of the country's rural population without access to medical care.

"That development would run counter to years of effort by the AMA, the federal government, and other groups to increase the number of physicians practicing in underserved areas.

"There still remain problems in small rural counties in physician availability that will not, in the next 15 years at least, be simply solved by the slipover, or the diffusion, or trickledown of the growth in physician supply," said David A. Kindig, MD, PhD, who headed the study for the National Rural Health Association.

Why the rural problems?

What are the problems of attracting physicians to care for pa-

Continued on next page

Michigan agencies are tackling the problems of getting and keeping physicians in rural areas.

These agencies include the Michigan Department of Public Health (MDPH), Michigan Health Council (MHC), Michigan Primary Care Association (MPCA), and the Office of Health and Medical Affairs (OHMA).

OHMA expects to release soon the results of a physician census it has been conducting the past three years. The census previously was made annually by the MDPH, but was picked up by OHMA in 1986. OHMA has given the survey renewed emphasis in response to increased public interest in physician shortage areas.

According to Ken Darga, health policy consultant, OHMA will update its physician census information each year with the one-third of Michigan physicians who renew their licenses.

Rick Murdock, health planning specialist, reports OHMA is awaiting word on an application for federal funds to support a Cooperative Agreement Program for Primary Care Services.

OHMA has applied to the Department of Health and Human Services for the funds. If the request is approved, the Michigan agency will begin its project in October.

"This will give us the opportunity to pull all primary care interest groups together and examine what is going on in terms of resources and providers avail-

able," says Murdock.

"It's clear there are areas of the state in need," he says. "It's unclear yet if it's a matter of redistributing physicians or training more."

The proposed Primary Care Services Program would 1) enhance the state's ability to collect and analyze data on physician demographics, to identify service needs; 2) allow OHMA, on behalf of the state and agencies involved in primary care, to develop a needs assessment to complement OHMA's provider data; 3) allow the state to strengthen the physician recruitment program of the Michigan Health Council; and 4) allow the state to establish a primary care forum, where key players could develop consensus on approaches to the problems.

Murdock believes the physician shortage problem has been fairly constant over the past decades, with variances from area to area.

"However, the liability situation, particularly in obstetrics, is exacerbating the situation," he points out. "If you take the only OB out of a rural community, it affects a wide area."

Sarah Banks, Primary Care Association executive, thinks the shortage of physicians is a severe problem in Michigan's rural areas. She believes the actualities are worse than what is reported.

"We're losing over 50 percent of our newly-trained physicians, you know," she points out.

Continued on page 467

SPECIAL REPORT/Continued

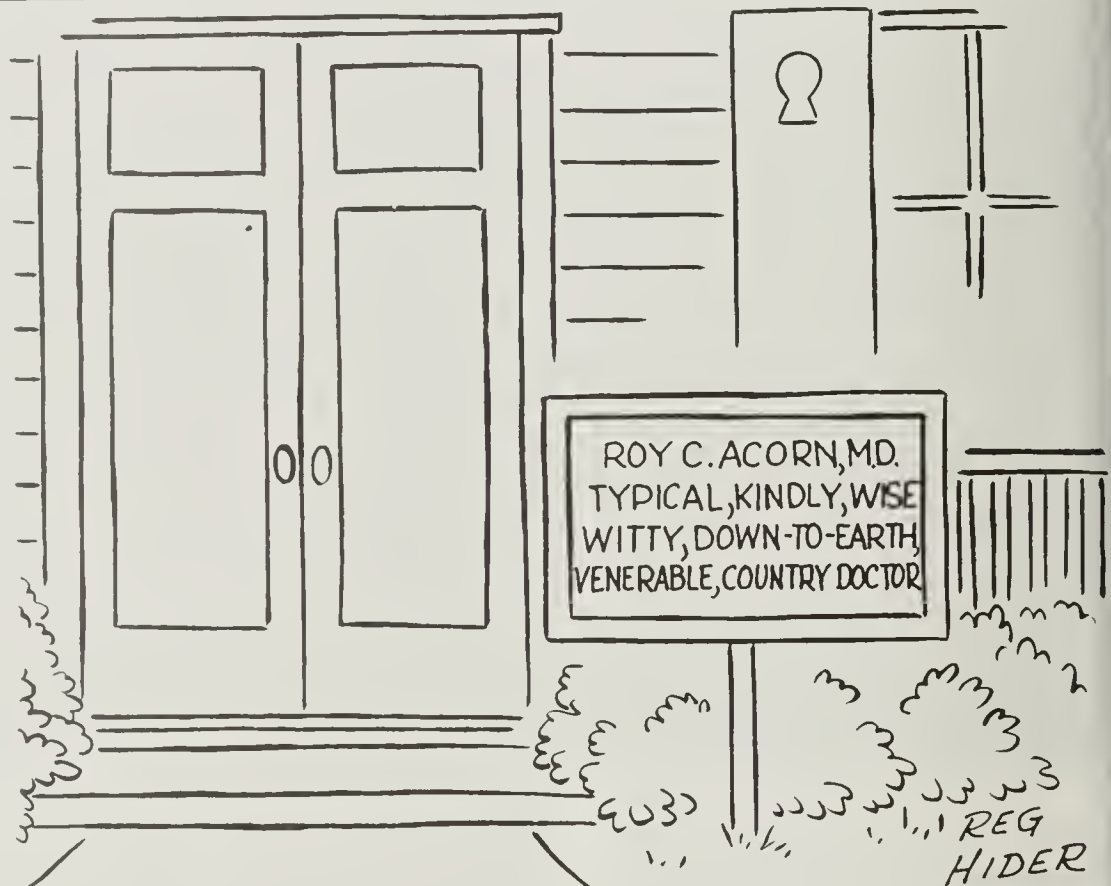
tients in rural areas? The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research described well the factors that must be considered. In a 1983 report entitled "Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services," this group wrote:

"Decisions by physicians to locate in a particular area are governed by many considerations. Potential income, the site of the physician's medical training, the geographic background of the physician and spouse, social and cultural opportunities in the area, the presence of other physicians, and the opportunities for continuing education all contribute to the decision about where to practice medicine. Physicians, like everyone else, are concerned about the quality of life available to themselves and to their families."

Rural practices generally are busier than their big-city counterparts, observed the author of the cover story of the November/December 1987 issue of *Hippocrates—the Magazine of Health Medicine*. Such practices have an average of 35 percent more office visits per week.

Rural practices are more expensive to operate, as they require larger supplies of equipment and medicines to treat the wide variety of conditions seen, said *Hippocrates*.

Most patients in rural America



tend to be poor, so the doctor charges less. A larger proportion are elderly. But because the 1983 Medicare Reform Act assumed that operating costs were lower in rural areas, Medicare reimburses rural doctors less for their elderly patients—sometimes only half as much, continues Patrick Cooke, author of the *Hippocrates* article.

Peer review organizations monitor physicians who treat Medicare patients, and can exclude them from Medicare altogether if they find the doctor in violation of acceptable standards. Most of the 50 doctors censured in the last two years were from rural areas.

"Long hours, low pay and second class status in the professional community—not the kind of thing that pulls all the best and

the brightest out into the country," says Cooke.

The new survey reported by the *American Medical News* found low pay, long hours and distance from major referral centers as the greatest causes of dissatisfaction for rural physicians.

Michigan problems

The Michigan Health Council, which has maintained the official Michigan physician placement service since 1953, lists 251 physician openings in Michigan: approximately 75 percent are in more rural areas.

Jim Tarrant, president, Michigan Health Council, illuminates another problem specific to Michigan.

In September, 1985, Tarrant

testified before a Michigan House Subcommittee on the impact of the professional liability insurance climate on the Health Council's ability to recruit physicians for Michigan communities.

"The Michigan Health Council is concerned with increasing reports of physicians leaving practice, reducing services offered and moving to other states, which hamper our efforts to retain physicians trained in Michigan," he said.

"Physicians leaving practice increase the perceived maldistribution and further inhibit our efforts to encourage physicians to locate in places needing physicians, especially in rural areas and high risk, inner-city areas."

A just-completed MSMS survey adds statistics to the impressions: Over three-fifths of Michigan resident physicians responding to an MSMS survey this spring reported they do not intend to practice in Michigan. Those who reported they are leaving the state overwhelmingly cited the malpractice climate and liability insurance costs as major factors in their decision. Forty-three of the respondents indicated they had planned to practice in Michigan before entering their residencies but now plan on going out of state. Of those, 39 listed the malpractice climate as a major factor.

Historical perspective

"During the 1960's, the distri-

Continued on next page

SCARCE/Continued

MPCA has primary care placement opportunities listed in all 21 of its rural Comprehensive Outpatient Centers, she says.

The MPCA, which represents the federally-funded Comprehensive Outpatient Centers (formerly neighborhood health

"MPCA is looking at the number of, and specialty mix of, physicians in high-need areas in the state."

centers), is working on a primary care plan for the state, in coordination with the MDPH.

MPCA is looking at the numbers of, and specialty mix of, physicians in high-need areas in the state. The organization expects to complete its study by the end of September.

The MPCA also is looking at ways to retain physicians.

MPCA, MDPH and OHMA are working on a proposal for a medical student loan-forgiveness program to supplant the dwindling resources available through the National Health Service

Corps. The federal government has authorized such a program and will provide matching funds.

MDPH has proposed the solution to attract and retain obstetricians. MPCA would like to extend the incentive to all primary care physicians.

Banks would like to see aggressive recruiting of Michigan-trained physicians who have left the state.

"I'm looking for a buy-out," she says. "If one of our physicians out of state is working under the National Health Service Corps, or any other loan program, I'd like to see Michigan offer to buy out the physician's loan, if he or she will come back."

She believes Michigan should develop its own state health service corps, patterned after the national version.

"We are expecting one—no more than six—physicians in Michigan from the NHSC in the next placement year," she laments. The NHSC has had problems obtaining recruits because of its reputation for allowing no options for Corps volunteers, she believes.

She was grateful for an opportunity to discuss Michigan's rural physician shortages.

"We need all the publicity we can get," she explained. "The more people know of our problems, the better off we will be." □

SPECIAL REPORT/Continued

bution of health care resources was characterized as a 'feast-or-famine' situation: while most Americans had access to a wide range of health care providers, hospitals, clinics, nursing homes and supportive and ancillary services, the residents of many rural and inner-city communities faced serious shortages." That was the observation of the President's Commission for the Study of Ethical Problems in its 1983 report.

Congress anticipated a shortage of physicians in the 1960s by enacting legislation to increase the aggregate supply of health personnel through direct subsidies to professional educational institutions.

Nat'l Health Service Corps

In another move to correct physician supply and distribution problems, Congress established the National Health Service Corps (NHSC) in 1970. PL 91-623, the "Emergency Health Personnel Act," was designed "to improve the delivery of health services to persons living in communities and areas of the United States where health personnel, facilities or services are inadequate to meet the health needs of the residents of such communities and areas."

The Senate report which introduced the NHSC amendment described the viewpoint of the times—that the US suffered from a shortage of health professionals.

"But this shortage is particu-

larly acute in areas of urban and rural poverty, and in isolated rural communities generally," it continued. "Since impoverished and isolated areas lack the resources to attract and retain qualified health professionals, these professionals—like professionals in other occupations—tend to locate in prospering urban and suburban communities."

The Corps was to revitalize the Public Health Service and to target the underserved areas. The bill's sponsors hoped that medical schools and other instrumental groups would join the effort and that public service-oriented medical students and others would seek to serve with the Corps.

The National Health Service Corps exists yet. For every year of education the federal government subsidizes, the newly-graduated physician owes a year of full-time clinical practice in an area of the country, either inner-city or rural, where doctors are in short supply.

Since the program began, the Corps has placed roughly 15,000 health care workers. It has helped reduce the number of medically underserved areas from 6,000 to 2,000.

But according to one study, only 35 percent of Corps personnel have stayed to practice in their assigned areas after meeting their obligations. The recent study published in *American Medical News* found about 15 percent of small-town MDs were placed by the NHSC.

Shortage Areas

In the late 1970s Congress passed legislation designating official health manpower shortage areas (HMSAs) throughout the country. Both the National Health Service Corps and the Health Manpower Shortage Areas are concerned primarily with providing primary care to underserved populations.

The rules and regulations which followed this legislation and those establishing the National Health Service Corps said that any public or nonprofit private entity in a health manpower shortage area (HMSA) may apply for Corps personnel.

The three primary requirements for designation as a HMSA are:

1) The area is a rational one for the delivery of primary care services;

2) Either a ratio of 3500:1 population to full-time equivalent primary care physician, or a population-to-physician ratio of less than 3500:1 but more than 3000:1 and an unusually high need for primary care services, or insufficient capacity of existing primary care providers, or;

3) Primary care givers in contiguous areas are inaccessible to this area's population.

The HMSA and an Index of Medical Underservice are the most widely used standards for designating geographic areas or populations as underserved today.

Continued on page 470

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Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



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C I B A

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Arbitration: An alternative to the courts

Introduction

Arbitration is an alternative to the court/jury system for resolving disputes arising out of health care treatment. The Michigan Medical Arbitration Program began in 1975, as part of the Michigan Legislature's response to the medical liability crisis of the 1970s.

The purpose of this **Physician's File** is to provide background information about arbitration, and explain why it is a viable alternative to the court/jury system. Included are some questions and answers about arbitration, and information on offering arbitration to your patients. The following is an excerpt from "Medical Malpractice Crisis the Second Time Around: Why Not Arbitrate," by Rhoda M. Powsner, MD, JD, and Frances Hamermesh, JD; *Journal of Legal Medicine*, Volume 8, Number 2, 1987. For a reprint of the complete article, contact Mary Anne Ford at MSMS.

Arbitration: An historical view

Arbitration, like the court/jury system, is a decisional form of dispute resolution, unlike mediation or negotiation with which it is often confused. It is not a method of compromising, but of deciding disputes. Also like the court system, an arbitration award is "final and binding" on the parties, but they must agree to this before the award is known. Yet, arbitration differs from the traditional court system for resolving disputes in two essential ways — it cannot be initiated without mutual agreement of the parties, and the person making the decision has no formal connection with the court system. Each of these four characteristics of arbitration is essential.

Although the fundamental principles of arbitration are durable and have remained virtually unchanged over the centuries, its use in dispute resolution in other than the traditional areas of commerce and labor has been largely eclipsed by the development of the formal court system and the rapidly expanding legal profession. Recently, however, a growing realization of the inability of courts to handle an increasing load, and of the formal legal system's ineffectiveness in handling disputes, has resulted in a renewed interest in arbitration. The Michigan Legislature demonstrated its interest in 1975 with its adopted statutes to permit binding arbitration of medical malpractice disputes.

The Michigan Arbitration Statutes

The Michigan Legislature enacted the Medical Malpractice Arbitration Program as part of the total 1975 medical malpractice package by amending the state general arbitration statute and the insurance code. The key amendment to the insurance code, requiring that all companies selling professional liability insurance to hospitals ensure, as a condition of doing business in the state, that their insureds offer the arbitration option to patients, brought the program into existence. Other amendments to the insurance code specified that the Michigan Arbitration Act was binding on all hospital employees and set a required level of independent practitioner participation. In addition, an advisory committee to the insurance commissioner and an Arbitration Administration Fund were created, with the provision that the insurance commissioner, in consultation with the advisory committee, develop rules and forms for the implementation of the program.

The Arbitration Agreement

The companion bill, which amended the general arbitration statute, contained the provisions governing the medical malpractice arbitration process. The bill made health care providers, hospitals, or their agents liable for injury or death caused by "error, omission, or negligence in the performance of professional services..." and/or for "performance of such services without consent, in breach of warranty or violation of contract." There are safeguards to ensure that the patient agreement to arbitrate is voluntary. The arbitration agreement must state that signing of the agreement is "not a prerequisite to care" and the patient or legal representative may revoke the agreement within 60 days after discharge. The agreement for hospital care is valid for each individual contact unless there is continuing treatment on long-term outpatient basis, in which case a signed agreement will expire at the end of one year.

Offerers not only must explain the agreement completely prior to obtaining a signature, but also must provide the patient with an informational booklet. The agreement cannot be offered to a patient in the emergency room until the completion of treatment.



The standards set for arbitration proceedings in the amendment to the general arbitration statute are consistent with those applying to civil actions in Michigan. Several provisions are worth noting because they have served as bases for legal challenges. The arbitration panel consists of three arbitrators: a physician, health care provider, or hospital administrator; a lawyer; and, a public member. The American Arbitration Association (AAA) submits lists of potential arbitrators to the parties, who may then strike names from each category. If mutual agreement is not achieved after the submission of two sets of arbitrators in any category, then AAA itself may appoint the arbitrator in that category. An agreement signed by a parent or legal guardian binds the minor child who "may not subsequently disaffirm the agreement." If, in cases involving a common question of law or fact, there are separate arbitration agree-

ments between the plaintiff and a number of defendants or between defendants, the issues "shall be consolidated into a single arbitration proceeding."

Evidentiary issues

The arbitration statute also deals with evidentiary issues. The hearing process is informal and "the rules of evidence shall be provided under the rules of the association except that the panel shall adhere to civil rules of evidence where the failure to do so will result in substantial prejudice to the rights of the part." Expert testimony is permitted, but not required:

The party with the burden of establishing the standard of care and breach thereof shall establish such standards whether by the introduction of expert testimony, or by other competent proof of the standard and the breach thereof, which may include the use of...authoritative, published works on the general and specific subjects in issue.

The panel may also "call a neutral expert on its own motion."

The Michigan Medical Malpractice Arbitration Program shortens the usual discovery period. While court rules require completion of discovery within one year after the answer is filed, the arbitration statute specifies that "discovery shall commence not later than 20 days after all parties have received a copy of the demand for arbitration and shall be completed within 6 months." The lawyer/chairperson of the panel has jurisdiction over prehearing procedures. Claims enter the system when they are filed with the AAA under a signed agreement or, in the absence of an agreement prior to the delivery of healthcare, claims may be arbitrated when all parties agree to submit the dispute to arbitration.

The 1975 Medical Malpractice Arbitration Statutes incorporate the salient features of arbitration. There is an independent third-party decision maker; the award is on the merits and is not intended to be a compromise; the decision is final and binding; however, while participation is voluntary for patients, involvement by hospitals covered under the statute is mandatory. The rule-based nature of the system affords some predictability, but because of the private nature of the process and restrictions on dissemination of information about the awards, decisions are not precedent setting.

MICHIGAN MEDICAL ARBITRATION PROGRAM SUMMARY CASE STATISTICS

	CALENDAR YEAR	CASES FILED	CASES CLOSED
	1976	2	0
	1977	19	4
	1978	54	14
	1979	86	30
	1980	86	40
	1981	76	68
	1982	62	111
	1983	31	88
	1984	94	44
	1985	67	82
	1986	76	85
	1987	57	67
Jan.-Apr.	1988	20	20
	TOTALS AS OF 4/30/88	730	653

Some Common Questions About the Michigan Medical Malpractice Arbitration Program

What is arbitration?

Arbitration is an alternative to the court-jury system. A three person panel of arbitrators will hear and make a final decision about a dispute arising out of health care treatment — other than a dispute about fees.

What is the Michigan Medical Malpractice Arbitration Program?

In 1975 the Michigan Legislature passed two laws offering a choice between arbitration and the court-jury system to resolve disputes arising out of health care treatment. These two laws require most hospitals, clinics and sanitariums to offer an Arbitration Agreement to patients.

When is arbitration offered to patients?

In most cases, an arbitration agreement is offered before health care treatment begins — generally, at the time of admission to a hospital or clinic. Physicians may also offer arbitration to their patients. Patients being offered an Arbitration Agreement must also be given a Patient Information Booklet, which provides a detailed explanation of the Arbitration Agreement.

Can the Arbitration Agreement be canceled?

Yes. Patients may cancel the agreement by written notification within 60 days of signing the agreement. After the 60 day period, the decision to arbitrate cannot be changed.

Can patients choose arbitration after they have a claim?

It is possible for patients to wait until they have a claim before making a decision about arbitration. But, arbitration must be agreed upon by both parties to the claim.

How is going to arbitration different from going to court?

In arbitration, a case is heard by a three person panel, rather than by a judge and jury. The three person panel consists of a physician or a person from a hospital, an attorney and a member of the public. Both parties to arbitration take part in the selection of the panel, from a list of arbitrators developed by the American Arbitration Association. The length of an arbitration hearing and the time from filing to decision are generally shorter than going to court. And, in most cases, the decision of the arbitration panel is final and cannot be appealed.

How long does the arbitration process take?

Currently, the average length of arbitration is 16.9 months from date of filing to final decision. The average arbitration hearing takes two days.

Can I present my full case in this shorter time period?

Yes. In arbitration it is not necessary to schedule time on crowded court dockets, and hearings are conducted from 9:00 a.m. to 5:00 p.m. with little interruption. But, the arbitration process permits both sides to present all appropriate proofs, witnesses and documentation, just as in court.

Is there a state official responsible for overseeing the Michigan Medical Arbitration Program?

The Michigan Commissioner of Insurance. Contact the Michigan Insurance Bureau, Department of Licensing and Regulation, P.O. Box 30220, Lansing, MI 48909: (517) 373-2984.

Who can answer my questions about arbitration?

If you have questions, or if you are interested in serving as a member of a medical arbitration panel, contact the American Arbitration Association at 1-800-482-0660.



Arbitration Agreement Forms and Patient Information Booklets Available

The following Arbitration Agreement Forms are approved by the Michigan Insurance Bureau for use by physicians:

- IBA 100: Physician-Patient Outpatient Form
Applies only to treatment or care rendered in the Physician's office for one year.
- IBA 106: Physician/Patient Form
Applies to treatment or care rendered in the physician's office or in a hospital for one year.
- IBA 107: Physician/Patient Hospital Stay Form
Applies to treatment or care rendered in a hospital for one year. (May be used in conjunction with IBA 100.)

Both IBA 106 and 107 specifically include coverage for any assistants or substitutes assigned by the primary physician. However, neither agreement includes the hospital, its employees or independent staff doctors or consultants. All forms must be accompanied by a Patient Information Booklet.

The forms and booklets are available at cost from MSMS. For prices and ordering information, contact Mary Anne Ford at MSMS.

This form is approved by the Michigan Commissioner of Insurance

ARBITRATION AGREEMENT PHYSICIAN-PATIENT OUT-PATIENT FORM

ARBITRATION IS A WAY TO DECIDE HEALTH CARE COMPLAINTS WITHOUT GOING TO COURT

By signing this agreement, my doctor(s) and I are choosing arbitration rather than going to court as a way of deciding any future claim about my medical care. This agreement applies ONLY to the care that I receive in this office during the next year. This agreement does NOT apply to disagreements over the fees charged.

Michigan law gives me a choice of two ways to decide claims: either a trial by a judge or jury OR arbitration. I have the right to a lawyer for either a trial or arbitration.

If I select arbitration, my case will be decided by a panel of three people instead of a judge or jury. The arbitration panel will contain a lawyer, a member of the public, and a doctor or other health professional. My doctor(s) and I will take part in choosing the panel members who will decide the case. If the parties involved in the case cannot agree on the panel members, the American Arbitration Association may appoint the panel members. Michigan laws and the rules of the American Arbitration Association will apply to all arbitration hearings.

I am choosing arbitration of my own free will. This agreement applies to me, my heirs, and my legal representatives. This agreement also applies to any professional corporation or partnership that my doctor belongs to or works for. If I want to change my mind and cancel this agreement, I MUST notify my doctor IN WRITING within 60 DAYS AFTER I SIGN. After 60 days, I cannot change my decision.

In most cases a decision by an arbitration panel is final and cannot be appealed.

I have read this agreement or have had it read to me. I have received the booklet which explains this agreement.

THIS AGREEMENT TO ARBITRATE IS NOT A PREREQUISITE TO HEALTH CARE OR TREATMENT, AND MAY BE REVOKED WITHIN 60 DAYS AFTER EXECUTION BY NOTIFICATION IN WRITING TO:

Signature of Physician Representative

Patient Name (Type or Print)

Address

Patient Signature

Date

Patient Address

(I certify that I am the parent of the minor child, the guardian, or other legal representative of the patient involved.)

INSTRUCTIONS FOR USE

Give Booklet with proposed agreement to patient. If agreement is signed, place duplicate original in patient's file.

Name of parent, legal guardian or other legal representative (type or print)

Signature of parent, legal guardian or other legal representative

FOR FURTHER INFORMATION CONTACT: AMERICAN ARBITRATION ASSOCIATION
1000 Ford Building • Detroit, Michigan 48226 • Phone: (800) 482-0660

IBA 100
Approved 12/1/75
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**In vitro* activity does not necessarily imply a correlation with *in vivo* results.

†Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

CIPRO® SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.



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Please see adjacent page of this advertisement for Brief Summary of Prescribing Information.

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C09327 MLR-261



■ 500 mg B.I.D. for most infections;
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BRIEF SUMMARY

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INDICATIONS AND USAGE

Cipro[®] is indicated for the treatment of infections caused by susceptible strains of the designated micro-organisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Pseudomonas aeruginosa*, *Haemophilus influenzae*, *Haemophilus parainfluenzae*, and *Streptococcus pneumoniae*.

Skin and Skin Structure Infections caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Proteus vulgaris*, *Providencia stuartii*, *Morganella morganii*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains) *Staphylococcus epidermidis*, and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae*, *Serratia marcescens*, and *Pseudomonas aeruginosa*.

Urinary Tract Infections caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Serratia marcescens*, *Proteus mirabilis*, *Providencia rettgeri*, *Morganella morganii*, *Citrobacter diversus*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus epidermidis*, and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni*, *Shigella flexneri*,* and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro[®] may be initiated before results of these tests are known, once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACODYNAMICS SECTION IN FULL PRESCRIBING INFORMATION)

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS)

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness, therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below

- Salmonella/Microsome Test (Negative)
- E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V79 Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed

Pregnancy - Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in

CONVENIENT B.I.D. DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg B.I.
Bone and Joint*	Severe/Complicated	750 mg B.I.
Skin/Skin Structure*	Mild/Moderate	250 mg B.I.
Urinary Tract*	Severe/Complicated	500 mg B.I.
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg B.I.

pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS)

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS)

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, compared to 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%)

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%)

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized

GASTROINTESTINAL (See above), painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM (See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia

SKIN/HYPERSENSITIVITY (See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyperpigmentation, erythema nodosum

SPECIAL SENSES blurred vision, disturbed vision, (change in color perception, overbrightness of light), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste

MUSCULOSKELETAL joint or back pain, joint stiffness, achiness, neck or chest pain, flare-up of gout, renal/uridgenital interstitial nephritis, renal failure, polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin

Adverse Laboratory Changes Changes in laboratory parameters listed as adverse events without regard to relationship

Hepatic - Elevations of ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)

Hematologic - eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%)

Renal - Elevations of Serum creatinine (1.1%), BUN (0.9%)

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED

Other changes occurring in less than 0.1% of courses were: Elevation of serum gamma-glutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, and bleeding diathesis, increase in blood monocytes, and leukocytosis

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours

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In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

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IN MY OPINION/Continued

izations justify their existence is by demonstrating to the government the amount of money saved. In our example, 10 TURs initially were denied; however, three of the patients requested a second physician review and all of these were approved. In the final accounting, only seven cases (0.14 percent) were denied.

There are many other hidden administrative costs in the MPRO system. Add in the telephone costs, the postage, the physician

reviewer charges, and you have a very costly system. Every physician also must assume the additional overhead of the authorization call. It is not unusual for this to tie up an office nurse for 15 minutes.

Based on the above information, it seems reasonable to propose the elimination of this program. It is obviously not cost effective. But don't hold your breath. □

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The plight of the family doctor

By Michael Buenafior, MD

Editor's note: The following article appeared in the April 11, 1988 issue of *U.S. News & World Report* and is reprinted here with the permission of the author.

"The remedy isn't just a matter of assigning surplus doctors in other specialties . . . to step in and play family doctor."

Society has agonized over the imperiled existence of the humpback whale, the bald eagle, the buffalo of the Great Plains and, on occasion, the farmer on the prairie. We should add the American family doctor to the list.

This may seem surprising, since Americans have been repeatedly told about doctor surplus. Health campaigns alerting the public to specific diseases, new drugs or health hazards usually direct people to their "family doctor," as if everyone had one and as if family doctors were in plentiful supply.

But conservative estimates put the deficit of family practitioners at 25,000 by the year 2000. Even today, there are only 50,000 of us, and we care for an average of 3,000 patients each.

The remedy isn't just a matter of assigning surplus doctors in other specialties, who lack any formal training or experience in primary care, to step in and play family doctor. When specialists with available time resort to family practice to make a living, they tend to order more tests and to charge fees in keeping with what

one would expect of specialists.

In 1985, the American Medical Association's Council on Long-Range Planning and Development reported that between 1970 and 1982 the number of family doctors declined by one tenth of one percent. Compare that with a 164 percent increase in gastroenterologists and a 447 percent jump in radiologists. A study done in 1978 showed that 67 percent of family doctors died by age 59. By comparison, 88 percent of ophthalmologists and 94 percent of ear, nose and throat specialists lived beyond 60.

The simplified explanation for this is that family physicians undergo far more wear and tear on the mind, body and soul than their counterparts. We often find ourselves confronted by patients who coerce us to falsify work excuses, disability claims and insurance applications for their own financial gain. Because we are accessible, we also absorb more of the public's wrath over a myriad of medical issues for which we are not personally responsible. Family doctors did not create the growing population of elderly people who are a major

factor in higher U.S. medical costs. It is not the fault of family doctors that AIDS will contribute many billions to the national medical debt. Nor is it the fault of family doctors that Americans seem to have an insatiable appetite for all of the newest and most-expensive technology, but at the same time an aversion to medical-cost containment that involves them or their families.

Even as family doctors are notified of a 300 percent increase in the cost of immunizations or a 200 percent increase in malpractice premiums, we must deal in a businesslike and empathetic manner with patients who assume we can wait to be paid until after they have dealt with bills from specialists, auto mechanics and department stores. After all, we are "rich doctors" and the patients' friend. But the typical family doctor does not make the often quoted "average" doctor's salary of about \$112,000 a year. On average, we earn 20 to 25 percent less.

We often feel like the rat trapped in an experimental box.

Michael Buenafior, MD, practices family medicine in Northampton, Penn.

Continued on page 492

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Frank B. Walker, MD, elected to AMA Board of Trustees

Frank B. Walker, MD, chairman of the MSMS board of directors, was elected to the 14-member Board of Trustees of the American Medical Association during the AMA's annual House of Delegates meeting held in June in Chicago.

AMA's 420 delegates, representing 295,000 members, elected Doctor Walker to a one-year term. He is Michigan's second physician to serve in the highest ranks of the AMA in recent years; John J. Coury, MD, of Port Huron, is AMA's immediate past president.

Doctor Walker, 57, a Grosse Pointe Farms pathologist, has been a member of the Michigan delegation to the AMA since 1974 and has served on the AMA Council on Long Range Planning and Development since 1982.

"Challenges currently facing physicians and our patients are tremendous," Doctor Walker said, "but they can be met through hard work, determination and cooperation."

"Throughout my term I will work to resolve the medical liability crisis, to address issues brought on by the AIDS epidemic and to control government over-regulation," Doctor Walker said.

"We must work to solve these problems and get on with our larger mission for which we entered this profession; advancing medicine, improving health in the community and bettering the quality of life in this country," Doctor Walker said.



Frank B. Walker, MD

A 1955 graduate of Wayne State University School of Medicine, Doctor Walker has practiced in the Detroit area for 25 years where he and his wife, Ginny, raised four children; Nancy, David, Roger and Mark.

In 1984-85, Doctor Walker served as president of the Wayne County Medical Society, the second largest county medical society in the country with over 4,000

members.

Doctor Walker has held positions as president of the Michigan Society of Pathologists and the American Society of Clinical Pathologists. He is currently treasurer of the American Board of Pathology.

Doctor Walker has privileges at Detroit-Macomb Hospital Corporation and Cottage Hospital. □



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Young physicians conference slated for October 6

By Betty J. McNerney, Managing Editor

The MSMS Task Force on Young Physicians, in cooperation with Physician Service Group (PSG), an MSMS subsidiary, will sponsor a conference on Financial and Medical Practice Management on Thursday, October 6, at the Hyatt Regency Hotel in Dearborn.

The day will consist of five 45-minute sessions on a variety of topics aimed primarily at the physician just setting up practice. A question and answer period will follow each session.

Morning sessions will include:

(1) **Evaluating a Practice Opportunity.** This session will highlight valuable questions to ask during the employment interview. Featured speaker will be John Anthony, of Medmark Corporation, Lansing. Anthony currently serves as a practice management consultant to physicians and medical groups.

Also speaking at this session will be Ann F. Putalaz, economist and vice president, Trust Division, Comerica Bank, Detroit, who will present an overview of the economic climate in Michigan for physicians just starting practice.

(2) **Alternative Healthcare Finance Systems.** This session will offer young physicians and resident physicians valuable insight into the risks and rewards associated with becoming affiliated with an HMO, PPO or IPA. Featured speaker(s) to be announced.

(3) **Evaluating Contracts, Malpractice Coverage and Pro-**



The planning committee met recently to complete the program for the October 6, MSMS medical practice management conference. The conference is sponsored by the MSMS Young Physicians Section, and will be held at the Hyatt Regency Dearborn. From left around the table are Mitchell Rinek, MD, Lansing; Thomas E. Stone, MD, Mt. Clemens, chairman, MSMS Young Physicians Section; Thomas J. Archambeau, MD, Lansing; Jack A. Dekkinga, MD, Jenison; and Tama D. Martini, MD, Ann Arbor.

tecting Your Assets. This session will address contracts and the types of decisions physicians face when entering into a group practice or other employment situation. Other topics include how to interview potential employees, and how to determine the average cost of establishing a practice. Featured speaker at this session will be MSMS legal counsel Richard D. Weber, of Kerr, Russell and Weber, Detroit.

Afternoon sessions will include:

(1) **How to Select Your Professional Advisors & Tax Planning.** Featured speaker at this session will be Earl Romans, CPA, PC, Southfield.

(2) **Retirement Planning.** Featured speaker at this session will be Julius H. Giarmarco, JD, LL.M., of Giarmarco and Bill,

PC, Troy. Well-known to many MSMS members, Giarmarco is considered an expert in the field of retirement planning.

Conference attendees will also have the opportunity to learn about "The Political Future for Young Physicians in Michigan," at the conference luncheon. Featured speaker will be Rep. James A. Kosteva (D-Canton).

Registration for the one-day conference is \$50 per person for MSMS members, \$75 for non-members, \$15 for MSMS Resident Physician members, and \$20 for non-member resident physicians. Registration fee includes workshop materials, refreshments and luncheon.

To register, or for more conference information, contact Amy Fistler at MSMS.

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MSMS holds news conference on all-terrain vehicles

By David K. Fox

Media from across the state attended the MSMS news conference May 19 at the Capitol to announce the Society's public awareness campaign on the dangers of all-terrain vehicles (ATVs).

MSMS President-elect Robert E. Paxton, MD, showed the MSMS television public service announcement and MSMS President Fred W. Bryant, MD, endorsed Senate Bill 708, the ATV regulation legislation introduced by Senator John J.H. Schwarz, MD, of Battle Creek. Hosting the conference was B. Elliot Gysen, MD, JD, of East Lansing, who is spearheading the ATV campaign for MSMS.

Mr. Fox is MSMS chief of media relations.

Guests included Attorney General Frank Kelley, Secretary of State Richard Austin, Sen. Schwarz, a representative of the Governor's office and Constance Doyle, MD, of the Michigan Chapter of the American College of Emergency Physicians. All spoke to the need of tighter ATV regulation and supported MSMS in its public awareness campaign.

Since the news conference, television stations across the state have aired the public service announcement frequently. Several, however, have been intimidated by a threatening letter from the Michigan Motorcycle Dealers Association. The MMDA said dealers were intending to file a complaint with the Federal Communications Commission because they felt the spots were "unfair."

MSMS responded with a news release about the threats. The resulting media coverage helped raise the issue even more in the public's mind. MSMS is asking Michigan State Medical Society Auxiliary members to call television stations in local areas to encourage airing the public service announcement.

Since 1982, nearly 50 people have been killed as a result of ATV accidents in Michigan; nearly half were children under 16. About 1,000 people have died in ATV accidents nationwide.

Sen. Schwarz's bill calls for an age restriction of 16, mandatory helmet use and eye protection, and the punishment of drivers using alcohol or drugs the same as if they were driving on-road vehicles. □



At a May 19 news conference at the Capitol in Lansing, MSMS President-elect Robert E. Paxton, MD, addressed media representatives on the dangers of all-terrain vehicles.



"From both a medical and legal viewpoint," said B. Elliot Gysen, MD, JD, East Lansing, at the May 19 news conference, "we are compelled to warn the public that their children are in danger." Doctor Gysen, who is spearheading the ATV campaign, hosted the conference.



"Children are being killed and crippled at an alarming rate by all-terrain vehicle accidents," MSMS President Fred W. Bryant, MD, told news media at the MSMS news conference May 19 at the State Capitol. Doctor Bryant endorsed Senate Bill 708, which calls for the regulation and restriction of ATV use.

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James H. Sammons, MD
Executive Vice President



American Medical Association 535 North Dearborn Street; Chicago, Illinois 60610

VIEWPOINT/Continued

When the rat receives an electric shock, no matter which direction it goes in or what lever it pushes, its eating, sleeping, playing and mating behaviors deteriorate to the point of illness and death. There is, in fact, a good case to be made for awarding family doctors hazardous-duty pay.

The American Academy of Family Physicians just celebrated its 40th anniversary as a recog-

nized specialty. When the 50th anniversary approaches, it is not clear what there will be to celebrate or who will have survived to answer the question. The family doctors' condition may foretell the future health care of the nation. It will take growing awareness of the problem to preserve a human resource and protect still another endangered species for the ultimate good of all. □

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Good financial management keeps physicians competitive

By John Anthony, MBA

Editor's note: This is the second in a series of articles on practice management. These articles are being presented as a service of Physician Service Group Inc., an MSMS subsidiary. For more information on this or future articles, contact Amy Fistler at MSMS.

Physicians need to have more information about their medical practice in order to compete effectively in the years ahead.

Until recently, a medical practitioner could adjust fees and productivity easily to produce the gross income needed to support the cost of doing business, plus provide for a targeted profit. With new limits on practitioners, this no longer is an easy task.

With new Medicare rules, and dollar fee screens established recently by most third-party payors, it is imperative that physicians understand how they generate net income in their practice and how controls on the business or financial side of their practice can affect their profitability.

Physicians must measure certain statistics on a monthly basis. It is important that a medical practice know the gross revenues being generated and the source of these dollars. The practice must know how income is derived,

The author is a consultant to Physician Service Group Inc.

"The most informative statistic that physicians can monitor in their medical practices is . . . their accounts receivable."

i.e., dollars generated through medical ancillary testing, lab, x-ray, hospital activities or, simply, patient activities in the office.

The physician also must have a way of measuring the source of dollars generated. He or she must know how many dollars in gross revenues and net cash receipts come from each of the major sources of payment: Blue Shield, Medicare, Medicaid, other insurances, HMOs, and patient pay.

Monitor your accounts receivable

The most informative statistic that physicians can monitor in their medical practices is what is owed to them, or, in more common terminology, their accounts receivable. This is one of the few numbers within a medical practice that can be quantified and, therefore, is measurable.

The level of accounts receivable in relationship to the monthly gross charges tells the practitioner whether or not the staff is doing an effective job of collecting at the time of service, sending out prompt insurance

claims, following up on rejected or pending claims, and sending subsequent statements to the patients. Most practitioners should know what their accounts receivable are at the end of each month. Having an outside accountant or bookkeeper construct this number on a semi-annual or annual basis is simply not adequate.

Accounts receivable for most primary care physicians and other practitioners who have a lot of office-based visits should approximate 1.5 to 2.0 times monthly gross charges. For example, if a medical practice has gross charges of \$15,000 per month, the accounts receivable should be in the range of \$22,500 to \$30,000. The practitioners that will be an exception to this rule are those such as orthopedic surgeons or neurosurgeons who have a high percentage of their practice involved in workers' compensation cases, disability determination cases, or other cases that involve litigation. Our studies find that an average of 2.5 months of gross charges is more likely the case for these types of physicians.

Don't develop a false sense of security

Once we are monitoring the accounts receivable of a practice, we have to make certain that we don't fall into a false security with our analysis. A practitioner whose accounts receivables fall within these tolerable guidelines can actually have those dollars become worth a great deal less if they become older and more delinquent.

So, in addition to measuring the accounts receivable on a monthly basis, an aging of the receivables should be done at least each six months. This is the method of putting the dollars owed to the practice into categories of lateness. The percentage of receivables are getting later. Certain computer systems can easily provide this data. Also important is how much and how late are insurance receivables.

Most of the medical practices will accumulate large funds in the form of cash, to be paid out at the end of the fiscal year for employee pension plans or bonuses. Since, in an average practice, these dollars can accumulate to tens of thousands of dollars, it is quite important that these cash funds are invested in a vehicle that returns the principal plus interest. Most commercial banks will have a commercial checking account that will automatically sweep dollars from general checking account into an account that earns the practitioner interest on these excess funds. Although the rates are near or less

than money-market rates of interest, a great deal of interest income can be earned by most practices.

Frequent deposits desirable

It is vital that practitioners have deposits made to their bank account as frequently as is practical. It is desirable to have all funds deposited on a daily basis into the general checking account or interest-bearing account. In addition to the establishment of a better audit trail, this assures the optimization of the interest-earning capability of these funds.

Since most large expenditures for a medical practice come about on a pre-determined annual basis, the good medical practice will have its cash managed in a way that the dollars needed for these expenditures are in an investment vehicle earning the maximum rate of interest for the longest period of time.

Almost all of our medical practices have the ability to budget these major cash flow items and, consequently, should be taking advantage of the much higher rates of return on treasury bills and money-market fund accounts that are available to them, rather than simply assigning the funds to interest-bearing checking accounts at a commercial bank.

Good financial management will add two to three percent to the bottom line of most medical practices. Since this total accrues to the physician, it certainly is worth the effort. □

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The following reports were considered at the AMA House of Delegates Annual Meeting in Chicago, June 26-30, 1988. Copies are available by contacting Debbie Howe, MSMS Department of Communications, 120 W. Saginaw St., East Lansing, MI 48826-0950, (517) 337-1351.

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Report L—Monetary Fines as PRO Sanctions

Report M—Physician Payment for Case Management: Final Report

Report O—Policy Directions for the Public Financing of Long-Term Care Services

Report P—Physician Manpower

Report R—Organ Procurement System—Interim Report

Report T—Resident Physician Working Hours and Supervision

Report W—Maternity/Paternity Leave Policy: Informational Status Report

Report Z—Child Pornography

Report BB—Impact of Product Liability on the Development of New Medical Technologies

Report DD—Prevention of HIV Transmission in Prisons: Informational Report

Report KK—Adolescent Health: Background Report

Report OO—A National Study of Resource-Based Relative Value Scales for Physicians Services: Criteria for Evaluation and Recommendations for Implementation

Report PP—A National Study of Resource-Based Relative Value Scales for Physician Services: Status Report

Report RR—Status Report on Medicare "Medically Unnecessary" Services Problem

Report SS—Registered Care Technologists

Report UU—Medicaid—Towards Reforming the Program

Report YY—Status Report on Implementation of the Health Policy Agenda for the American People (HPA)

Report DDD—Joint Commission on Accreditation of Healthcare Organizations

Report GGG—Physician Payment Under Medicare

Report III—Report of the Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability

Report KKK—AIDS Status Report: Situation Update

Report LLL—Progress on the Prevention and Control of AIDS

Report MMM—Peer Review After Patrick vs Burget

Report NNN—Drug Abuse in the United States: A Policy Report

Reports of Council on Ethical and Judicial Affairs

Report A—Physicians Serving on Hospital Governing Boards

Report C—Euthanasia

Reports of Council on Medical Services

Report A—Protecting the Uninsured: AMA Proposals

Report C—Financing of Care for AIDS Patients—A Progress Report—Based on the San Francisco Experience

Report D—Financing Long-Term Care

Report G—Blue Cross and Blue Shield Medical Necessity Program: Diagnostic Testing Guidelines

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PHYSICIANS IN THE NEWS



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Robert G. Bulten, MD, Grand Rapids, was honored as "Allied Professional of the Year" at the Fall School Social Workers' State Conference. He was recognized for his work with children with Attention Deficit Disorder and for the establishment of a clinic at Baxter Community Center. . . . The University of Michigan Medical School has named Joseph C. Glorioso, PhD, Ann Arbor, assistant dean for research and graduate studies. Among his new responsibilities will be the establishment of a transgenic animal core facility and a coordinated program in AIDS research. . . . John J. Collins, Jr., MD, Ann Arbor, vice president, professional and physician services, Mercy Health Services, Farmington Hills, has been appointed to a three-year term to the Committee on Hospital Medical Staffs and the Quality Task Force by the American Hospital Association Board of Trustees. . . . Dorsey Ligon, MD, Grand Rapids, received the Eugene Browning Medical Award, which recognizes the contributions of local black people to the community, at the 5th Annual Giants Awards Banquet. . . . James J.



Brody

Rice, MD, FACS, Muskegon, and Andres G. Resto, MD, Port Huron, recently received three-year appointments as cancer liaison physicians for the cancer program at Hackley Hospital & Medical Center, Muskegon, and Port Huron Hospital, Port Huron. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. . . . Max Karl Newman, MD, Southfield, recently was cited by the president of the American College of Legal Medicine for his contribution made to the textbook *Legal Medicine: Legal Dynamics of Medical Encounters*. Doctor Newman wrote a chapter entitled, "Medical Technology," which covers the field of medical imaging. . . . Tom Tomlinson, PhD, associate professor, Medical Humanities Program, Michigan State University, and Howard Brody, MD, PhD, program director, have published "Ethics and Communication in Do-Not-Resuscitate Orders" in the *New England Journal of Medicine*. . . . The Michigan Society of General Surgeons elected E.J. Treisman, MD, Southfield, president, James W.



Brooks



Kobernick

Copping, MD, Port Huron, president-elect, and Thomas J. Przybylski, MD, Rochester, secretary/treasurer, at their annual meeting in Novi. . . . Beth Ann Brooks, MD, St. Clair Shores, has been elected president of the Michigan Psychiatric Society. Doctor Brooks, a child psychiatrist based at Lafayette Clinic, succeeds Ronald A. Selbst, MD. . . . The University of Michigan Board of Regents has appointed Paul R. Lichter, MD, director of the W.K. Kellogg Eye Center at the U-M Medical Center, to the newly created F. Bruce Fralick Professorship of Ophthalmology. The professorship is named for F. Bruce Fralick, MD, who was chairman of the U-M Department of Ophthalmology in 1938-68. . . . Michael S. Kobernick, MD, Huntington Woods, has been named Detroit-Macomb Hospital Corporation's corporate director of emergency services. Doctor Kobernick is responsible for the administration of the emergency care services departments of Detroit Riverview Hospital and Macomb Hospital Center. □

**ROSALYN P. STERLING-SCOTT, M.D.**

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

EDUCATION Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Axid[®] (nizatidine, Lilly)



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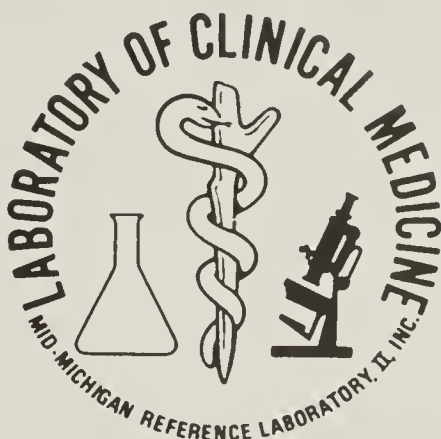
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U-M study links smoking with poor health habits

A new study from The University of Michigan Fitness Research Center (FRC) found that cigarette smokers are likely to drink more alcohol and use mood-altering drugs more often than nonsmokers.

They also tend to sleep less, fight more and take more risks — including not buckling up their seat belts, reported Professor Dee W. Edington, FRC director and director of the U-M's Division of Physical Education, and Louis Yen, U-M doctoral student.

In their study of 4,034 employees at a large manufacturing company, the typical smoker is a male under age 45. A non-college graduate, he is an hourly employee with an income less than

\$35,000 a year.

Non-smokers in the study are concentrated in the 45-and-older category and tend to have a higher socioeconomic status. "Higher percentages of non-smokers — including ex-smokers — reported their physical health as excellent or good, and stated they did not have chronic bronchitis emphysema," Edington and Yen said.

"However," Edington added, "when we looked at physiological measures such as percent overweight, hypertension and self-reported serious medical problems, ex-smokers, in fact, showed the worst health status. These people, the data suggested, may have quit smoking as a result of health and medical problems."

Ex-smokers and nonsmokers, however, miss fewer working days than smokers. Among current smokers, the higher the

number of cigarettes smoked per day, the more days missed at work.

Health care costs were compared for 2,617 participants who had worked for the company for at least three years and had made at least one health care claim. Non-smokers cost the company the least, ex-smokers cost the most, and current smokers fell in between.

"The findings, although based on just one company's experience, are important in light of the growing number of employers who are enacting or considering worksite smoking policies," the U-M researchers said.

The public favors such policies, they added. "In a 1986 Industry Week survey, 83 percent of the respondents said companies have a right to control or ban smoking at work. And, significantly, 48 percent of the smokers in the survey agreed."

STDs increasing, center reports

The incidence of sexually transmitted diseases other than AIDS has increased among sexually active men and women of all ages, at all levels of society, according to Shalom Z. Hirschman, MD, professor of medicine and director of the Mount Sinai STD center. In 1977, there were 64,621 cases of syphilis reported in the US; in 1987, there were 86,549. The increase is even more

Continued on page 505



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Before prescribing, please consult Brief Prescribing Information on next page.

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiaro SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride. Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiaro SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function; potassium-losing nephropathy, and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, furosemide) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE)

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS), other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 mL; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSEAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

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NEWSFRONTS/Continued

dramatic for chancroid, a less common STD: 445 in 1977; 4,998 in 1987.

In the 1980's, the public health spotlight has been understandably focused on AIDS, leaving awareness of other STDs at a dangerously low level. They are more common and contagious, and early detection and treatment can spell the critical difference between a cure — often with a simple course of antibiotics — and serious, irreversible

complications.

If left untreated, STD's can cause a wide range of serious and disabling complications such as heart damage, dementia, permanent loss of fertility among women, increased mortality in infants born to infected mothers, and conditions that may progress to cancer. For example, there is increasing evidence that the STD known as human papillomavirus (HPV) is implicated in cancer of the cervix. STDs are often harder to diagnose in women and therefore liable to go untreated longer

and cause greater damage, particularly to the female reproductive system.

Hospital stay for childbirth down to two days

In the United States in the 80s, the average length of stay in a hospital for a new mother and her baby following a normal delivery is just over two days, according to the Commission on

Continued on next page

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NEWSFRONT/Continued

Professional and Hospital Activities (CPHA), which has been collecting hospital length-of-stay data for more than two decades. According to PCHA, the hospital stay for a mother following a normal delivery has declined 42 percent in the past 17 years, going from four days in 1969 to 2.3 days in 1986.

CPHA, which is based in Ann Arbor, has maintained the largest single hospital length-of-stay database in the US since 1964. A non-profit organization, CPHA provides such data to hospitals, which utilize it in their efforts to maintain quality care while containing costs.

According to Jeanine DeLay, assistant director for research services, a number of factors have contributed to shorter hospital stays following childbirth. "Obstetrical practices have changed, as have our attitudes toward childbirth," says DeLay. "In addition, there have been declines in natural risk factors, prevalence of infectious diseases and infant mortality rates in urban areas of the United States."

Epilepsy info service expanded

The Epilepsy Foundation of America has discovered an unexpectedly large demand for information on its toll free telephone service in recent months. The Foundation, located in suburban

Washington, D.C., receives calls from all 50 states from people who have concerns about seizure disorders.

Doctor Ivan Lipman, Chicago, president of the Foundation, said the toll free service now provides information to as many as 2,000 callers per month. He said the service provides basic up-to-date information on epilepsy to both the general public and to medical professionals as well.

NIH consensus panel issues MRI report

A National Institutes of Health (NIH) consensus development statement on magnetic resonance imaging may be obtained from the NIH Office of Medical Applications of Research.

The report was prepared by a panel of experts that considered scientific evidence presented at a Consensus Development Conference at NIH. It contains recommendations and conclusions concerning magnetic resonance imaging.

At NIH, consensus conferences bring together researchers, practicing physicians, representatives of public interest groups, consumers, and others to carry out scientific assessments of drugs, devices, and procedures in an effort to evaluate their safety and effectiveness.

Free, single copies of the consensus statement on magnetic resonance imaging may be obtained from: Michael J. Berns-

tein, Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 216, Bethesda, Maryland 20892.

Nicotine conference set for September

The director of the U.S. Office of Smoking and Health will present a national perspective on nicotine use and dependence when the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAO DD) sponsors the First National Conference on Nicotine Dependence September 22-25 at the Hyatt Regency in Minneapolis.

Co-sponsoring the conference is the Minnesota Smoke Free 2000 Coalition. Richard Hurt, MD, director of the Smoking Cessation Center at Mayo Clinic, is conference chairperson.

Conference registrants will receive a syllabus containing abstracts of all presentations.

Information on registration and hotel reservations may be obtained from AMSAODD, 6525 W. North Avenue, Suite 204, Oak Park, IL 60302, (312) 848-6050. □

The Hutzel Fertility Center.

Hutzel Hospital has been providing primary research and clinical leadership in the reproductive sciences for more than a century. Today, working with the Wayne State University School of Medicine, Hutzel offers one of the most advanced, comprehensive and effective fertility programs in America. Some highlights:

- Couples are treated together at Hutzel. They are not, as a matter of course, referred out to individual, gender-specific specialists.
- Hutzel's in vitro fertilization accomplishments include:
 - Michigan's first in vitro fertilization babies.
 - One of Michigan's first ultrasound egg retrieval programs.
 - Michigan's first, and to date only, cryopreservation program (very important in reducing multiple birth risks).
 - Board-Certified reproductive endocrinologists at Hutzel have trained many of the specialists working in this area.
- In spite of its unique quality level, charges at Hutzel are generally slightly less than at local hospital clinics.
- The Hutzel Fertility Center's modern facilities are located on the Hutzel Hospital Campus at The Detroit Medical Center, and recently have been expanded by more than 40 percent to accommodate growing demand.

Couples undertaking any fertility program usually make substantial emotional and economic investments. By recommending the most comprehensive program, you offer your patients the greatest chance of success.

For more information about any of Hutzel's fertility programs, please call 745-0499 or 577-1066.



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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

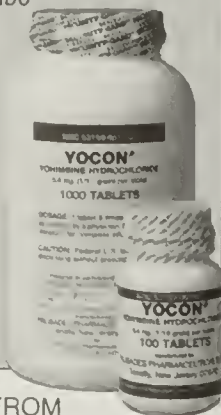
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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LETTERS/Continued

Public Act 10 of 1987 (Effective 8/6/88): Only a practitioner licensed under Article 7 of the Public Health Code may purchase schedule 1 schedule 2 controlled substance from a manufacturer or distributor. Authority to purchase is not assignable or transferable. Violation of this section is a misdemeanor.

Public Act 28 of 1988 (Effective 8/22/88): Requires prescriptions to indicate quantity of the controlled substance both numerically and in writing. Violation of this article may result in reprimand, probation, denial, suspension, revocation or limitation of license, restitution or fine.

Public Act 29 of 1988 (Effective 8/22/88): Prohibits an applicant or licensee convicted of a crime involving controlled substances, from having a financial interest in, or be employed by, an entity holding a controlled substance license for a minimum of three years. An individual who violates this subsection may be punished by a civil fine of not more than \$25,000.

Public Act 30 of 1988 (Effective 8/22/88): A license to manufacturer, distribute, prescribe or dispense a controlled substance shall be denied or revoked if the applicant or licensee has been convicted of a felony relating to a controlled substance. Penalty for refusing or failing to make, keep or furnish records changed from misdemeanor to four-year felony, or a fine of not more than \$30,000, or both.

Public Act 60 of 1988 (Effective 8/1/88): Creates a multiple copy prescription program which requires all schedule 2 controlled substances to be prescribed on a state issued prescription form. Prescription forms are free of charge and can only be obtained from the State of Michigan.

Public Act 61 of 1988 (Effective 8/1/88): Increases the annual controlled substance license fee to \$30-\$50.

If you have questions, concerns or would like further information, please contact me. Your cooperation in implementing these important new laws is greatly appreciated.

**C. William Howe, Director
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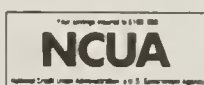
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DEATHS

John R. Brown, MD
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Doctor Brown died May 5 at the age of 82. He served as a staff member at Hutzel Hospital for 50 years, 20 years as surgical chief. He also was a member of Hutzel's Board of Trustees. Doctor Brown earned degrees from the University of Kentucky and the University of Pennsylvania.

Lee E. Feldkamp, MD
Canton

Doctor Feldkamp, a family practitioner in Plymouth for 30 years, died April 23, at the age of 71. He graduated from the University of Michigan Medical School in 1940. He underwent his internship at Grace Hospital, Detroit. In World War II, he was a medical reserve officer and received a Bronze Star. He was a charter fellow of the American Academy of Family Physicians, serving as president of the Michigan chapter and director of the national organization. He also was a member of the Wayne County and Washtenaw County Medical societies.

Everette Gustafson, MD
Pontiac

Doctor Gustafson, a Pontiac obstetrician/gynecologist, died May 17 at the age of 72. A graduate of the University of Michigan Medical School in 1944, Doctor Gustafson began his practice more than 40 years ago in Wakefield and came to the Pontiac

area in 1947. He was one of the founders of the Generals Club of Pontiac General Hospital, where he was once chief of staff and director of obstetrics. He was also a member of the staff of St. Joseph Mercy Hospital, Pontiac.

Edson C. Rupp, Jr., MD
Lake Leelanau

Doctor Rupp, a retired internal medicine specialist at William Beaumont Hospital in Royal Oak, died May 15 at the age of 74. A 1936 graduate of Denison University, Ohio, Doctor Rupp received his medical degree from Washington University, St. Louis, in 1942. Doctor Rupp interned and did his medical residency at Henry Ford Hospital in Detroit. He served in the U.S. Army Medical Corps during WW II. He was a member of the Oakland County Medical Society.

Casimer A. Skowronski, MD
Saginaw

Doctor Skowronski, a Saginaw physician for 47 years, died May 13 at the age of 73. Doctor Skowronski graduated from Wayne State University in 1939 and served his internship at St. Mary's Hospital. He was a member of the American Medical Association and the Saginaw County Medical Society, a past-president of St. Mary's Emergency Service and past-president of EMS Ambulance Service. He served on the senior staff committee at St. Mary's, St. Luke's and Saginaw General hospitals.

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Metric Medical Labs and the Medical Genetics and Birth Defects Center at Henry Ford Hospital are pleased to announce a joint program of alpha-fetoprotein testing for detection of neural tube defects and Down Syndrome.

Further information on this program is available through Metric Medical Labs and Henry Ford Hospital.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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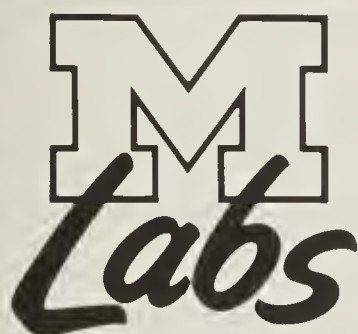
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

August

19-22, Cardiology Update. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 10 hours Category I Credit.

September

7, Cardiovascular Risk Factors in the Black Population—Special Emphasis on Hypertension. Location: Michigan Inn, Southfield. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 3.75 hours Category I Credit.

15, Effects of Cardiovascular Disease in the Older Patient. Location: Southfield Hilton, Southfield. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 3 hours Category I Credit.

15-16, Neonatal Emergencies. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Pediatrics and Communicable Diseases, Section of Newborn Services and Pediatric Pulmonary Medicine. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

15-17, 11th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical

School, Department of Radiology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 13 hours Category I Credit.

17, Cytopathology of Breast Lesions. Location: Henry Ford Hospital. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 5.5 hours Category I Credit.

19-20, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

22-24, 19th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan State University College of Human Medicine, The International Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. Contact: Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616)774-0440. Approved for: 18 hours Category I Credit.

26-27, Sexual Exploitation of Persons with Disabilities. Location: Michigan League, 911 North University, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Physical Medicine and Rehabilitation, Kenny Rehabilitation Foundation of Michigan. Contact: Gayle Fox, Office of Continu-

ing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

30, Management of Behavior Problems in Older Adults. Location: Sheraton Inn, Kalamazoo. Sponsor: Older Adult Program of Delano Clinic, Borgess Geriatric Center and Southwestern Michigan Area Health Education Center. Contact: Continuing Medical Education Department, Southwestern Michigan Area Health Education Center, (616) 341-6360. Approved for: 6 hours Category I Credit.

October

1, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 5 hours Category I Credit.

1, AIDS and Primary Care Physicians in Michigan. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 7 hours Category I Credit.

2, Michigan Chapter American Academy of Pediatrics Annual Scientific Meeting. Location: Grand Traverse Resort and Conference Center, Traverse City. Sponsor: Michigan Chapter American Academy of Pediatrics. Contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, MI 48018 (313)553-3646. Approved for: 7 hours Category I Credit.

3-4, Medical and Legal Perspectives on Impairment Evaluation and Disability Considerations of the Musculoskeletal System. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Surgery and Department of Physical Medicine and Rehabilitation. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

3-4, Ear, Nose and Throat Practicum. Loca-

tion: Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 17 hours Category I Credit.

4, Critical Clinical Issues in the Care of the Elderly. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 12 hours Category I Credit.

6-7, Nutritional Support: Physiology, Biochemistry, and Current Day Management. **Location:** The Towsley Center for Continuing Medical Education, The University of Michigan Medical School. **Sponsor:** The University of Michigan Medical School, Parenteral and Enteral Nutrition Team and Section of Pediatric Surgery, Department of Surgery. **Contact:** Debbie DeSmyther, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 10 hours Category I Credit.

6-7, Nutritional Support: A Return to Basics and Current Day Management. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Parenteral and Enteral Nutrition Team, Section of Pediatric Surgery, Department of Surgery. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

7, Diagnosis and Management of Lymphoma. **Location:** Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3072. **Approved for:** 6.5 hours Category I Credit.

14-15, 1988 Michigan Statewide Conference on Child Abuse and Neglect: Strategies for Successful Prevention and Treatment. **Location:** Towsley Center for Continuing Medical

Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 11 hours Category I Credit.

17-18, The Dilemma of the Complications of Diabetes. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, The Michigan Diabetes Research and Training Center, The Michigan Affiliate of the American Diabetes Association. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 13 hours Category I Credit.

November

2, Fifth Annual Conference on Alcoholism and Other Drug Dependencies. **Location:** Genevieve U. and Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsor:** Gateway Villa, KADAC, Southwestern Michigan Area Health Education Center. **Contact:** Continuing Medical Education Department, Southwestern Michigan Area Health Education Center (616)341-6360. **Approved for:** 6 hours Category I Credit.

15, Behavioral and Medical Perspectives of Obesity and Eating Disorders. **Location:** Henry Ford Hospital, 2799 West Grand Blvd., Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313)876-3072. **Approved for:** 6.5 hours Category I Credit.

18, Psychiatry for the Primary Care Physician. **Location:** Henry Ford Hospital, 2799 West Grand Blvd., Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313)876-3072. **Approved for:** 6 hours Category I Credit.

30, Diabetes Mellitus: Sexuality, Pregnancy and Aging. **Location:** Fairlane Manor, Dearborn. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313)876-3072. **Approved for:** 7.5 hours Category I Credit.

December

4-5, The Difficult Airway. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 13 hours Category I Credit.

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MEETINGS

MSMS MEETINGS

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

October

6, Financial and Medical Practice Management Conference, sponsored by MSMS Task Force on Young Physicians, Hyatt Regency Hotel, Dearborn, contact: Linda Munson (517)337-1351.

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517)337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

October

5-6, AMA Seventh Annual Science Reporters Conference, Westin St. Francis Hotel, San Francisco, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

26-30, AMA Ninth National Conference Impaired Health Professionals: Visions and Values, Chicago, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

December

4-7, AMA Interim Meeting, Dallas, Texas, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

August

19-20, Michigan Society of Thoracic Surgeons Annual Scientific Meeting, Grand Hotel, Mackinac Island, contact: Luis A. Tomatis, MD, President, 21 Michigan Street, N.E., Suite 550, Grand Rapids 49503 (616)459-6577.

October

2, Michigan Chapter, American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Resort and Conference Center, Traverse City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018 (313)553-3646.

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

NATIONAL SPECIALTY SOCIETIES

August

23-26, The American College of Physician Executives, The American Academy of Medical Directors First Executive Symposium on Health Care Management, Four Seasons Hotel, Vancouver, British Columbia, contact: The American College of Physician Executives, One Urban Centre, 4830 West Kennedy Boulevard, Suite 648, Tampa, FL 33609-2517 (813)287-2000.

September

14-17, American Group Practice Association Annual Meeting, Hotel Intercontinental, San Diego, CA, contact:

American Group Practice Association, 1422 Duke Street, Alexandria, VA 22314 (703)838-0033.

23-24, American Academy of Facial Plastic and Reconstructive Surgery Annual Meeting, Washington, DC, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202)842-4500.

26-29, American College of Emergency Physicians Scientific Meeting, New Orleans Convention Center, New Orleans, LA, contact: American College of Emergency Physicians, P.O. Box 619911, Dallas, TX 75261-9911 (214)550-0911.

October

1-6, American Academy of Family Physicians Annual and Scientific Meetings, New Orleans Marriott, New Orleans, LA, contact: American Academy of Family Physicians, 1740 W 92nd Street, Kansas City, MO 64114 (816)333-9700.

3-7, American College of Chest Physicians Scientific Meeting, Anaheim Hilton, Anaheim, CA, contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068 (312)698-2200.

8-12, American Academy of Ophthalmology Annual Scientific Meeting, Las Vegas, NV, contact: American Academy of Ophthalmology, P.O. Box 7424, 655 Beach, San Francisco, CA 94120 (415)561-8500.

8-12, American Society of Anesthesiologists Annual Meeting, San Francisco Hilton, San Francisco, CA, contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068 (312)825-5586.

17-19, American College of Gastroenterology Annual Meeting, Hilton, New York, NY, contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944 (617)927-8330.

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23-28, American College of Surgeons Annual Meeting, Hilton, Chicago, IL, contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611 (312)664-4050.

26-30, American Academy of Child and Adolescent Psychiatry Annual Meeting, Westin Hotel, Seattle, WA, contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.E., Washington, DC 20016 (202) 966-7300.

30-11/4, American Academy of Physical Medicine and Rehabilitation Annual Scientific Meeting, Convention Center, Seattle, WA, contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603 (312) 922-9366.

31-11/5, American Academy of Pediatrics Annual Meeting, San Francisco, CA, contact: American Academy of Pediatrics, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007 (312)288-5005.

November

2-5, The Wrist 1988, American Society for Surgery of the Hand, Saddlebrook Resort, Tampa, FL, contact: American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014 (303)755-4588.

12-16, American College of Allergists Annual Scientific Meeting, Westin Century Plaza, Los Angeles, CA, contact: American College of Allergists, 800 E. Northwest Highway, Suite 101, Mt. Prospect, IL 60056 (312)255-0380.

December

3-8, American Academy of Dermatology Annual Scientific Meeting, Washington, DC, contact: American Academy of Dermatology, 1567 Maple Avenue, P.O. Box 3116, Evanston, IL 60204-3116 (312)869-3954.

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CLASSIFIED

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GENERAL INTERNIST: Marshfield Clinic, a 260-physician multispecialty group practice, is seeking BE/BC general internal medicine specialists to join its expanding department in Marshfield, Wisconsin. The department is currently staffed by 23 general internists with immediate plans to add seven or more additional members. The current call schedule is generally one night per month and one out of five weekends. An internal medicine residency program, University of Wisconsin Medical School affiliation, Medical Research Foundation, and ongoing new developments, i.e. Geriatrics Evaluation Center and Walk-In Medicine contribute to a very stimulating environment. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to \$85,000 with salary in two years up to \$110,000. Fringe benefit package outstanding. Send CV and references to: David L. Draves, Department of Administration, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect (715)387-5376.

FAMILY PRACTICE. Marshfield Clinic is seeking BE/BC family practitioners to join its expanding department in Marshfield. The department is currently staffed by five family practitioners with plans to add

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NORTH DAKOTA: 35-physician multispecialty group seeking orthopedic surgeon, unlimited potential, desirable medium size community in large service area. Position carries exceptional first-year income and benefit package. Contact Robert Suleski, 250 Regency Court, Waukesha, WI 53186, 1-800-338-7107 or (414)785-6500 (collect in Wisconsin).

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ROCHESTER, MN PRACTICE OPPORTUNITY. Multispecialty group practice is recruiting in the areas of general anesthesiology, radiology, urology, and otolaryngology. For confidential consideration, please contact: Acton Sell Associates, P.O. Box 832, Dearborn, MI 48121. Telephone: (313)531-4441.

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Continued on next page

CLASSIFIED/Continued

ORTHOPEDIC SURGEON. A progressive 131-bed two hospital system is seeking a Board certified or Board eligible orthopedic surgeon to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801 (906)779-4502.

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"I want better odds than that."

Nursing shortage: A deepening dilemma

By Fred W. Bryant, MD

"For decades, perhaps as long as most of us can remember in our professional lives, there has been a shortage of nursing personnel."

For decades, perhaps as long as most of us can remember in our professional lives, there has been a shortage of nursing personnel. Judged serious now, it is calculated to multiply in the decades ahead.

Several factors contribute to the deepening dilemma. There are ever-increasing challenges to the time and skill of nurses. The accumulation of scientific knowledge and complex technology. Demands for detailed documentation dictated by defensive medicine. Burdensome bureaucracy at phone and desk full of impedimenta.

At the same time, new fields unfold for nurses, most of whom are women, giving them the chance to be doctors, administrators at all levels, and executives.

Baccalaureate nurse administrators favor the hiring of four-year graduate personnel over LPN and diploma RNs, while pushing for higher salaries. Advocates declare the intent is to upgrade the quality of nursing care and to attract and retain desirable recruits; detractors say it eliminates competition and is self-serving. Regardless of cause, the result is a severe shortage of



Doctor Bryant

bedside help, so that essentials such as IVs, bed pans, and analgesics are not always promptly provided.

A year or so ago the AMA, through its House of Delegates, asked itself to survey the situation and offer suggestions. A new category would be established, the Registered Care Technologist. This response was submitted through report SS to Reference Committee C of the AMA House of Delegates. The program would have two phases, basic and advanced, each nine months in duration, the first two months in book work, the subsequent seven months in on-the-scene training. According to the AMA concept, the plan is intended to attract recent high school graduates into

an immediate pool of bedside helpers, and would augment and cooperate with the existing system, not compete with it.

The scheme proves to be a lightning rod, attracting controversy. No less than a dozen nursing organizations asked, and were granted, the opportunity to testify before Reference Committee C. Most spoke in opposition to the initiative of the AMA, stating it reinvented the wheel, would be weak and ineffective, intrusive and meddling. Half a dozen were opposed to the mechanism of registration, preferring certification, if such a plan is to be. Physician comments urged cooperation with existing systems, but said surfacing of the plan emphasized the magnitude and urgency of the problem and requires action.

Conceived in crisis and christened in controversy, the program faces many challenges. To date, no definitive set-up has been announced. Who will teach, supervise, and authenticate? How will accreditation and verification be accomplished, within and beyond state borders? Designed to alleviate a shortage quickly, such a plan might, in reality, take years to install. It is early in the game; we shall see what develops.

Doctor Bryant is MSMS president.

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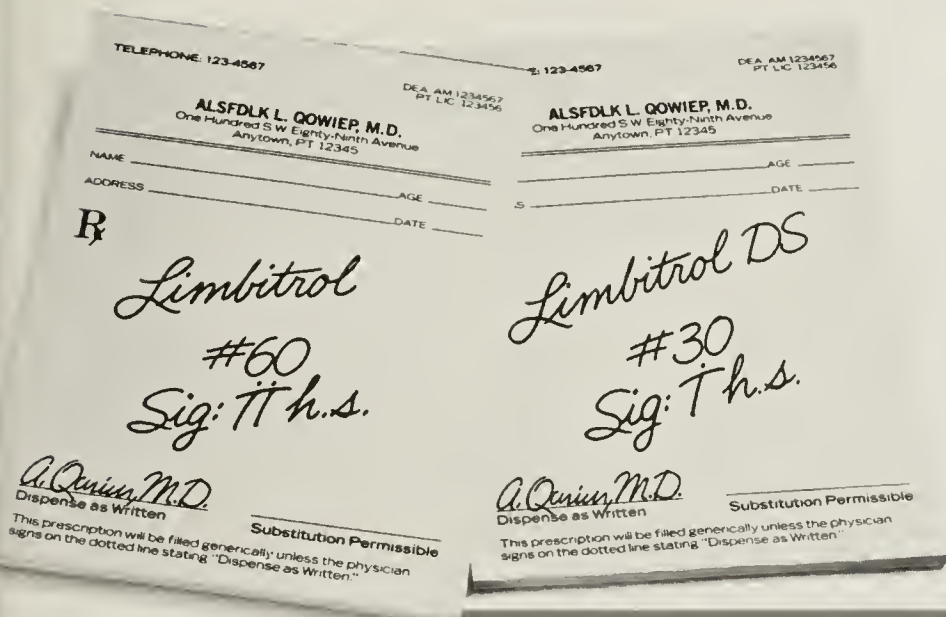
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

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Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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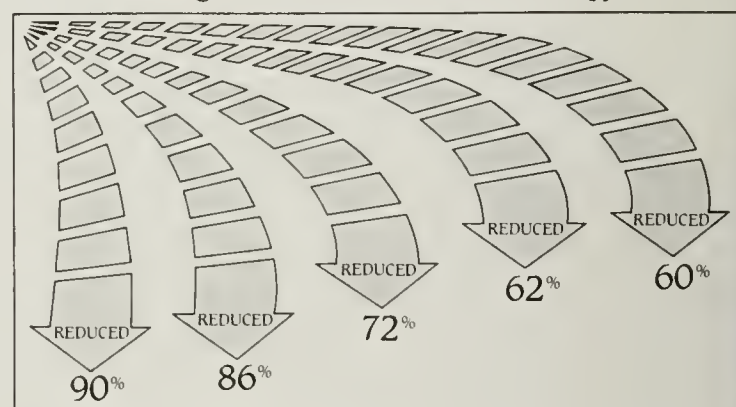
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M I C H I G A N MEDICINE

SEPTEMBER 1988 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY VOL. 87, No. 9

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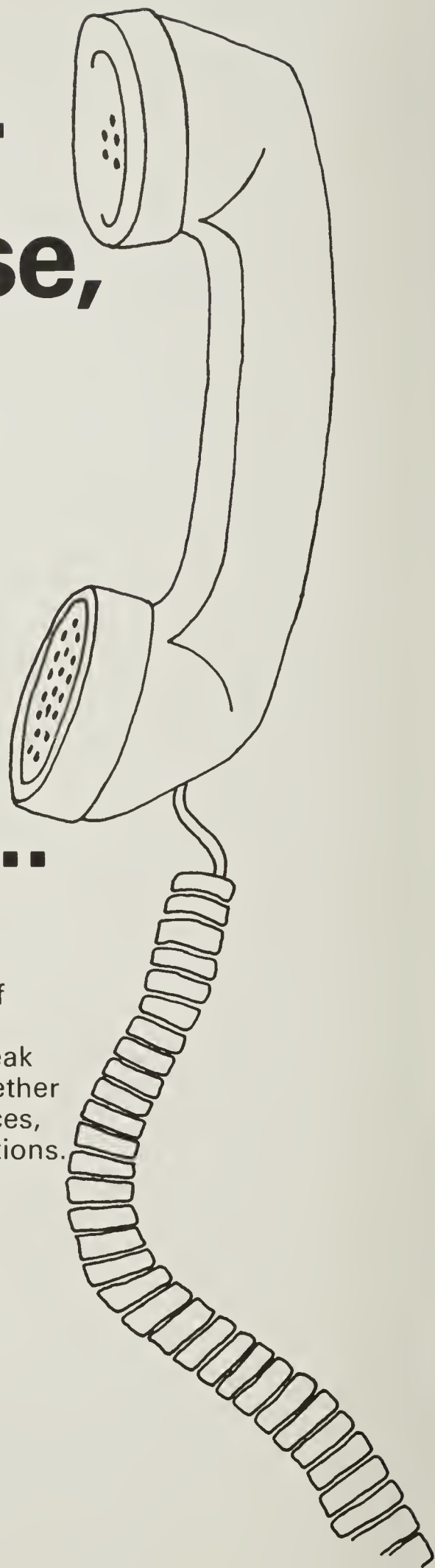
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M I C H I G A N M E D I C I N E

SEPTEMBER 1988 Vol. 87, No. 9

Special Report

An increasing number of adolescents in Michigan and across the United States are leading troubled, unhealthy lives. According to the AMA, one in four adolescents will suffer the consequences of school failure, drug abuse, teen parenthood, crime, or delinquency. The solution, says the AMA, is the creation of a unified national adolescent health initiative. An explanation of the AMA's call for a unified initiative is featured in this month's special report. Also included is an indepth report on adolescent health issues in Michigan, written by Karen Schrock, of the Michigan Department of Public Health; a look at the state's adolescent health programs, written by Rep. Alma G. Stallworth (D-Detroit); and a profile of The Corner Health Center in Ypsilanti, written by MSMS staff intern Chad Munger.

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Robert M. Leitch, MD

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Sen. John Kelly (D-Detroit)

An indepth profile reveals that health care insurance is a key concern for this Michigan senator — By Chad Munger

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1988 Annual Scientific Meeting

A preview of the upcoming MSMS event

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Joseph E. Johnson III, MD

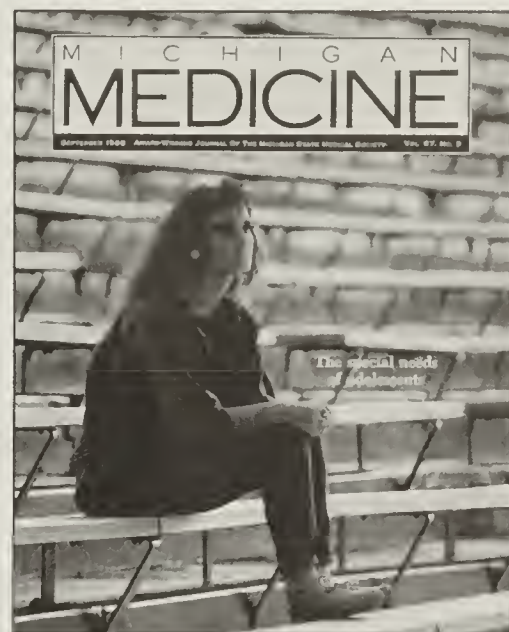
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In next month's issue of *Michigan Medicine*: MSMS Annual Scientific Meeting Convention Special.

Cover photo by: Michael J. Schimpf

Equal access to care does not ensure equal results

By Marguerite Shearer, MD

As a representative from MSMS, I was appointed to the Governor's Task Force on Access to Care. Forty people have been appointed. At the first meeting it was apparent that the Governor's perspective of the problem is such that he gave but one slot to physicians! The remaining members represent large and small employers, state government agencies, citizens groups, hospitals, and the insurance industry.

Our current system provides inadequate or no care for 20 percent of the population. The uninsured have to rely on the ad-hoc philanthropy of virtuous individuals. Therein lies the problem.

I agree with the premise that a health care system should be

Doctor Shearer is a member of the MSMS Committee on Publications.



Doctor Shearer

one means of assuring equity of opportunity among citizens. However, the public should not assume that equal health will result from it anymore than equal intelligence will result from high quality, equitable public education.

As physicians we are well

aware that health status results not only from access to care, but that nutrition, housing, heredity, health education, socio-economic stress, life-style, and general ability to use a health care system are all incredibly important. Equitable access can help, but will not remedy other factors in health status.

Equal access for primary and basic health care is needed. Individuals ideally should be free to discern when the attention of a physician is called for. Primary care physicians should decide if basic care is needed, and if so, equity of access at this juncture should reign.

The decision of how much health care is needed should be a collaborative one between the physician and the patient, both

Continued on page 542

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Patient education key to solving liability problem

Editor's note: The following are excerpts of a letter recently sent to Doctor Thomas R. Berglund, MD, regarding the issue of medical liability.

It seems to me that we, as physicians in Michigan, must strongly pursue a (medical liability) patient education format and program. I understand that this has been mandated in the recent Public Health Code, and wonder what MPMLC is doing along this line, as well.

My basic philosophy, as I have written to you in the past, is one of honesty and frankness in our dealings with the public about medical problems. I have even gone so far as to feel that we

Continued on page 564

CORRECTION

In the August 1988 issue of *Michigan Medicine*, it was reported that Public Act 60 of 1988, which creates a multiple copy prescription program, went into effect August 1, 1988. The program does not go into effect until August 1, 1989.

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AMA calls for a unified nat'l adolescent health initiative

By Betty J. McNerney, Managing Editor

"Images of troubled adolescents abound and pervade every socioeconomic stratum from teenage gangs roaming inner city ghettos to groups of affluent teenagers listlessly roaming through sprawling suburban malls. The risk of substance abuse, teenage pregnancy, and emotional disorders threaten all children as they make the transition to adulthood. Many succumb; one in four will suffer the consequences of school failure, drug abuse, teenage parenthood, crime, or delinquency."

— AMA Background Paper
on Adolescent Health

Adolescent health is "one of the most important and perplexing issues facing society today," says the AMA.

In the last few years, the AMA has been actively searching for ways to "advance the cause of adolescent health." Among the AMA's most recent efforts was a three-day National Congress on Adolescent Health, held last May in Chicago.

Designed for physicians and other health care professionals, as well as educators, social workers, community service workers, and counselors, the conference addressed the major categories of adolescent health problems, including sexuality/pregnancy, emotional disorders/suicide, victimization/homelessness, and injury/illness. A special feature of the conference was a series of workshops that showcased local, regional and national level programs that are currently and effectively promoting adolescent health.

During the closing session of the conference, Alan Nelson, MD, chairman of the AMA

Board of Trustees, expressed the AMA's "very firm commitment" to developing strategies for dealing with adolescent health problems, and for a unified national adolescent health initiative. Excerpts of his address follow:

"If there is a single message that has come out loud and clear in this landmark gathering, it is that even more than we might previously have imagined, the health of our youth is a complex and multi-faceted subject. Though the majority of America's adolescents will make the transition to adulthood without any permanent scars, for those adolescents who are most at risk, the causes of their problems are deeply rooted... There are no easy solutions.

"While none of us can solve all the complex issues of adolescent health, together we can begin to change the prognosis for adolescents at risk... It is called a Unified National Initiative for Adolescent Health.

"Two years ago, the AMA acted as an umbrella organization to stimulate the formation of

horizontal coalitions to address adolescent health issues. These issues are difficult for government agencies to address because of political sensitivities... difficult for the religious community to address because of varying religious tenets... and difficult to address solely in the educational setting because of the social sensitivities. But under the umbrella of a unified initiative, we can utilize government, religious, and educational resources and those of medicine, and business and civic leadership as well.

"We are mounting our educational campaign because we want America's doctors to understand what a huge impact they can have on kids' emotional and physical development, as well as the current state of their health. And we also want to be sure that doctors have the special skills to communicate with adolescents and to address their hidden concerns.

"As we conclude this first National Congress, I want to leave you with the words of Theodore Thornton Munger, a nineteenth century clergyman from New Haven, Connecticut. In one of several books about youth, he wrote: 'Youth is the opportunity to do something and to become somebody.' This is what adolescent health is all about. Together we have it in our power to give our young people the opportunity to do something with their lives and the chance to become somebody."

Adolescent health a priority for Michigan, says MDPH

By Karen Schrock

Teenagers typically are strong and healthy. Or at least, that is what many people believe.

In actuality, adolescents in many Michigan communities and communities across the country impart a different image—that of troubled, often unhealthy, individuals. Special health care programs have been designed for young children, poor and needy adults, and the elderly, but few programs have been designed for the special needs of teenagers. This may not seem out of line until realizing that adolescents comprise the *only* age group which has seen increased morbidity and mortality in the last 25 years.

Many of the health problems of youth are the same as those of the general population.

But in addition, they experience health problems markedly different than those of other age groups, characterized mostly by the changes of puberty, peer pressure and lifestyle choices. Throughout the country, almost 15 percent of adolescents age 16-17 report no regular source of medical care. In economically deprived areas that percentage is even higher. For example, before one community opened a school health clinic, more than 50 percent of the teens did not have a family physician. The Robert Wood Johnson National School Health Service Program found that 83 percent of the health



Bob Brent

problems which were diagnosed when students were examined for the first time at a school health center previously had been undetected. For many young people, poor health is the result of the accumulated effects of inaccessible health care throughout childhood combined with unhealthy lifestyles.

Michigan adolescents and young adults also suffer from a number of serious health problems. Eighty percent of deaths among adolescents 15-24 years old in Michigan are due to homicide, accidents and suicide. The suicide rate among 12 to 18-year-olds has tripled in the last 20 years and continues to rise every

year. Forty percent of Michigan's high school seniors can be classified as heavy drinkers, with six percent consuming alcohol on a daily basis. Sixty percent of high school seniors have used an illicit drug, and half of the admissions to substance abuse treatment centers are persons under the age of 21.

Other significant problems of Michigan teens are the high rates of sexually-transmitted diseases (which have increased by 58.9 percent for 10-14 year olds since 1976), a pregnancy rate of 91.5 per 1,000 in those aged 15-19 years, and over 16,000 births to

Continued on next page

The author is Chief, Eastern Regional Division, Bureau of Community Services, MDPH.

SPECIAL REPORT/Continued

teen mothers each year. Forty percent of Michigan teens display one or more of the following risk factors: smoking; drinking; over-eating; poor diets or unmanaged stress, which if not altered, can lead to heart disease, stroke, cancer and other diseases in adult life.

In 1985, these alarming statistics caused Governor James Blanchard and Gloria Smith, PhD, former Director of the Michigan Department of Public Health (MDPH), to make adolescent health a priority for Michigan. A five-year plan was developed for Michigan with strategies based on the conviction that adolescent health services must be accessible, appropriate for the age group and affordable.

The focus of Michigan's five-year plan is the establishment of teen health centers. This focus was taken as a result of national studies which showed that school-based health centers were effective in improving the health status of teens.

Evaluations in various school-based clinics throughout the country have shown a decrease in risk-taking behaviors, an increase in compliance with treatment protocols for sexually-transmitted disease, a decrease in the pregnancy and birth rate, delays in the initiation of sexual activity, decline in infant mortality rates, decreased use of emergency rooms for routine health care, and earlier detection of health



Bob Brent

problems.

The current program in Michigan focuses on a well-designed and thorough needs assessment process in which community input and local decision-making are key. The first step in this process is the establishment of a local, broad-based advisory committee. The local advisory committee guides the needs assessment, estimated to take at least 12-18 months. During this time, surveys are conducted among the adolescent population to determine health status, level of risk-taking behaviors, current health care needs and attitudes about health care. In addition, surveys usually are conducted among a random sample of parents and community members to identify needs, attitudes and current utilization of health care services by teens and families.

Community development is critical in order to build local

support for responding to the identified health care needs of teens in the community. Results from these surveys are used to determine whether a teen health center is appropriate for that community or if another method, such as coordination of services or enhancement of existing services, would alleviate the assessed problems. Some communities are able to support these assessment activities with local funds; however, state support is needed in the majority of communities. About half of the communities that complete a needs assessment decide to develop a teen health center.

In the spring of 1987, the Michigan Legislature passed the first appropriation specifically for adolescent health. Program requirements were developed by the MDPH in keeping with MDPH and state legislative requirements. The first program requirements were issued in May of 1987 and became effective October 1, 1987. At that time, there were six teen health centers in operation, the oldest of which began in 1979 (The Corner Health Center in Ypsilanti. A profile of the Center appears on page 534).

To continue receiving state funds for adolescent health, existing centers were required to comply with the new program requirements. In addition, Requests for Proposals were issued for new teen health centers and year-long planning (needs assessment) efforts. Five additional teen health centers were funded

and nine planning grants, beginning October 1, 1987. A similar process occurred in spring of 1988. An additional five teen health centers and seven new planning grants will begin October 1, 1988.

Centers which have received MDPH approval are located in Baldwin, Benton Harbor, Detroit (3), Flint, Highland Park, Inkster, Muskegon Heights (2), New Haven, Pontiac, Port Huron, Taylor, Warren, and Ypsilanti. Each is designed to meet the specific needs of the community it serves. The center model is determined by community demographics, need and resources.

Michigan does not require a center to be school-based; however, systems must be in place to make the center as accessible as possible to a large number of teens. Center models in Michigan include school-based (in the school), on school property (modular units or buildings on the school campus, but separated from the school), school-linked (centers placed in the community closely linked to a school or schools), and community-based (centers placed in the community with little or no relationship to the schools).

Each center/community designs its own service package, parental consent policy, and personnel policy. MDPH requirements include, for example, a certain composition of the advisory committee to ensure a broad base; compliance of advisory committee meetings with the



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Open Meetings Act; adequate facilities which ensure privacy and accessibility to the handicapped; and appropriate hours to assure accessibility to teens.

A pediatric or family nurse practitioner or a physician must be at the center as the primary care provider during all hours of operation. Most of Michigan's centers employ a full-time nurse practitioner and a part-time physician. Additionally, staff at the centers usually include an LPN or medical assistant, social worker/counselor and receptionist. Community agencies, such as the local substance abuse services or community mental health services, often provide staff to the centers for a few hours each day. This is done as a way to serve the difficult-to-reach adolescent population which presents at the teen health centers and may not routinely use other community agencies.

The MDPH-funded teen health centers are required to provide primary care services which are based on the student health survey and have been recommended by the local advisory committee. Services available to teen health centers may include the following: physical examinations for sports or employment; health screenings; diagnosis and treatment of minor, acute conditions; chronic disease management; immunizations; gynecological examinations; family planning services or counseling; pre-natal and post-partum services and counseling; well-child care for infants and children of adolescents; oral health assessment and referral; nutrition education and counseling; substance abuse prevention; and mental health counseling.

EPSDT (Medicaid health

Continued on next page

SPECIAL REPORT/Continued

screening) must be provided in all teen health centers. Centers funded with state money are prohibited from providing abortion counseling, services or referral. All centers must comply with all federal, state and local laws or regulations which apply.

The six teen health centers open in 1987 served approximately 6,000 individuals (unduplicated) between the ages of 0-23. 17,000 visits were recorded in the first year. During these visits, over 20,000 services were provided in the following general categories: chronic disease management; family planning; health promotion/risk reductions; immunizations; mental health services and counseling; prenatal/postpartum care; sexually-transmitted disease diagnosis and treatment; substance abuse diagnosis and treatment; and general medical. Forty-seven percent of services were for general medical, 25.9 percent were for health promotion/risk reduction and 16.2 percent were for family planning. The remaining categories constituted a small percentage of the services provided. Females constituted 64 percent of the clients serviced and 64.8 percent were black.

Future plans for Michigan's adolescent health program include the addition of new centers, planning grants, and adolescent health delivery demonstration projects. Five demonstration projects will be funded in fiscal year



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1988/89. These projects will improve accessibility to existing health care through case management, health education and/or referral. Many are located in rural areas. Future expansion will be influenced by the availability of funding and the outcome of the centers. An estimate has been made that Michigan may need as many as 100 teen health centers in middle, junior and senior high schools. This would represent placement of centers in approximately seven percent of the schools serving adolescents.

Several evaluation strategies currently are being started. These include an evaluation of the effectiveness of the teen health centers and a statewide random survey of teens to document baseline data on health status, behaviors, and health care needs. Inclusion of smoking prevention

and cessation programs in all centers is being considered since the overwhelming majority of adult smokers begin to smoke before the age of 19.

Teen health centers in Michigan and across the country are effective in reaching a population that previously was unreachable. For teens, health care services must be accessible both in terms of time and place. They need to feel the services are appropriate for their age with surroundings adapted to their interests. They need services they can afford.

All of Michigan's teen health centers have incorporated these principles into the design of their facilities and services. Special components at some off-campus centers include transportation and release time from school. Other centers have gone beyond traditional health care by providing programs to improve self-esteem, confidence and hope in disadvantaged youth. Such program offerings include grooming and etiquette classes, career days, theater troupes, and peer counseling.

Teens, while making the transition toward adulthood, need to have opportunities to learn to use health services appropriately, to understand the influence of lifestyle and behavior choices on future health status, and to have a place to receive help for physical and emotional problems. Michigan's teen health centers are providing this opportunity and meeting this need. (References available upon request). □

Adolescent health programs are gaining importance in Michigan

By Alma G. Stallworth, State Representative

Health programs targeted for adolescents are becoming increasingly important in Michigan. Many recognize the benefit of identifying health problems early, of promoting healthy lifestyles at a young age, and of developing targeted health programs for adolescents.

In Michigan we have responded to adolescent health needs through a variety of programs. As examples, we have instituted the Michigan Model for Comprehensive School Health Education in our public schools, passed legislation which allows teens access to prenatal care without parental consent, funded the development of adolescent health centers, and expanded Medicaid eligibility so more children and families have health insurance.

Approximately 400,000 students from kindergarten through eighth grade are currently receiving some health education through the Michigan Model for Comprehensive School Health Education. The program developed by the Departments of Education and Public Health is a statewide effort to help students learn the skills, knowledge, and attitudes necessary to lead healthy lives.

The goal for 1991 is to expand the program to reach 90 percent of all school districts, covering over a million students in all

Alma G. Stallworth currently serves as State Representative for northwest Detroit's 4th Legislative District.



Rep. Stallworth

grade levels. It will require the use of more state and federal money to achieve this goal.

In 1983, based on a recommendation from a document, "Barriers to Early Prenatal Care in Michigan," I negotiated passage of legislation to amend the Public Health Code to allow a minor to consent to her own prenatal care and the care of her child. P.A. 153 of 1984 eliminated one of the barriers to early prenatal care, thus supporting the goal of encouraging such care in order to enhance the outcome of the pregnancy. Prenatal care can save lives and money by reducing prematurity, low birthweight, and infant morbidity.

The Department of Public Health, through funding from the Legislature and the Governor, has spent approximately \$1.25 million in 1987 for the development of adolescent health centers. There are now 11 such centers across the state, and 15 communities using planning

grants. (The experience of these centers is detailed in an accompanying article.)

The federal government has encouraged increased access to health care through expansion of Medicaid eligibility. Federal legislation passed in 1987 allows states to extend Medicaid coverage to pregnant women and their young children in families with income up to 185 percent of the poverty level. Michigan recently agreed to institute such an expansion. This expansion will allow our state to use another resource to respond to infant mortality.

Legislation has been introduced in the House to mandate periodic child health screenings and to provide for parenting education in public schools. Also, the House and Senate Public Health Appropriations Subcommittees continue to support cost-effective early intervention and prevention programs such as family planning and genetic screening. These programs are cost containment strategies which save money.

While these efforts are laudable, more can be done. All levels of government need to work together with businesses, health care professionals, and communities to develop and participate in programs which support adolescent health. In addition, we need to do further research and data collection to ensure that the programs we provide produce results. Small initiatives for children can yield tremendous benefits for our society in years to come. □

For Ypsilanti youth, health care is "just around The Corner"

By Chad Munger

For adolescents and their children living in Ypsilanti, "good health care is just around The Corner." So says Joan Chesler, PhD, executive director of The Corner Health Center in Ypsilanti.

Founded amid a rising teen birth rate, inadequate low-cost medical care and a financially distraught educational system, The Corner Health Center staff has taken a bold, creative approach to solving adolescent health problems in Ypsilanti.

Although the Corner Health Center staff recognizes and addresses the need for education in solving adolescent health care problems, it offers much more than just talk.

"It is our contention that providing education is a good thing to do," says Doctor Chesler. "It is equally important to provide quality medical services to those for whom education does not work. 'You can't put all your marbles on education.'"

Its emphasis on medical care distinguishes The Corner from other outwardly similar clinics. The Center's ability to provide a minimum of one physician four days a week is quite unusual for an adolescent health care clinic and is made possible by its proximity to the University of Michigan's hospitals.

A symbiotic relationship has evolved between University



physicians and The Corner Health Center. This relationship is focused on the physicians in the U-M Family Practice Department, who, at the founding of the Center, were searching for a place to expose medical students to adolescent gynecology.

The Corner provides the ideal solution. Today it provides the gynecology rotation for the Department of Family Practice, which in return provides medical care to the Center's patients.

As Doctor Chesler puts it, "we scratch each other's backs."

The success of the Center cannot be attributed only to the presence of physicians; the Center's fresh approach to adolescent health care also has proven to be very attractive to area youth.

Center staff members aim to develop independence and self-respect in their patients. They require responsibility and initiative on the part of their patients and in return, treat them with dignity and respect for themselves and their health care needs.

The Center staff concentrate on providing a professional environment with well-kept, pleasant surroundings, because "kids should feel as though they are as important as any adult, full-pay patient," says Doctor Chesler.

"We at The Corner Health Center see ourselves as bridging the gap between the pediatrician and the adult health care world," she states.

For young patients the clinic is a place to take on new responsibilities and learn about the workings of the adult health care world.

"One of the things we see ourselves doing is teaching patients to become medical consumers. That means making and keeping appointments even if they are calling at noon for a one o'clock visit," says Doctor Chesler. "We want to see our patients be responsible for their health care management."

Young patients facing adult problems are in need of services that cannot be found in most traditional adult health care programs. The Corner Health Center has developed a number of special services to meet just those kinds of needs.

"One of the ways we differ from adult clinics is that we make

The author is an intern with the MSMS Department of Communications.

follow-up calls on all our contraceptive patients for at least the first three months," says Doctor Chesler.

The Center also offers counseling from a group known as peer educators. Peer educators are teen mothers, some of whom were patients of the Center, who have received intensive training in birth control.

The Corner Health Center staff sees the full range of health and social problems come through the door. But, according to Doctor Chesler, "reproductive health still is our biggest problem."

The Center provides programs both in and out of the clinic to educate and treat young mothers and their children. Inside the clinic the peer educator group runs the birth control education program, through which all patients receiving contraception must pass.

Patients going through this counseling seem to learn more and retain it longer than those who are counseled by adults, according to Doctor Chesler. "The reason peer educators are more effective is that young people have a less difficult time listening to people their own age," she says.

The peer educator group also works outside the clinic, often in the classrooms of local schools. In the schools, the peer group, along with the Center's own theater group, gives presentations and performs skits about substance abuse, pregnancy and a host of

other health related problems faced by young people. Both of these programs have been very well-received by the surrounding community.

Wherever adolescents and medicine meet there is bound to be controversy, especially when birth control and pregnancy are a part of the picture. Abortion

"The Center's fresh approach to adolescent health care has proven to be very attractive to area youth."

and parental consent for medical treatment are two particularly hot issues the Center must face.

For The Corner Health Center, how to deal with abortion is a very clear-cut issue. Because the Center is partially funded by the Department of Public Health, it is absolutely prohibited from participating in any counseling or treatment involving abortion.

Unlike abortion, parental consent is a topic which the Center must deal with itself. According to Doctor Chesler, "We encourage but do not require consent for medical services which do not legally require it."

The Center has found that

parents are generally receptive to this policy and that more than anything they just seem to appreciate the services the Center provides.

It is not at all unusual to find parents accompanying children to the clinic. "Parents of our patients are very pleased," says Doctor Chesler.

Being relatively young, like the patients it serves, the Center is experiencing some growing pains of its own. In only six years the Center's patient load has increased tenfold. This rapid increase in patient population has meant the need for new and bigger facilities.

In 1987 the Center acquired a new building in downtown Ypsilanti which has allowed them to expand and specialize their staffing. The new room has made way for a social worker on duty 12 to 15 hours a week and for two additional treatment rooms. The Center now is able to offer EPSDT exams for Medicaid-eligible children and a similar pediatric clinic for non-eligible kids.

As the need for specialized adolescent health care in the Ypsilanti area has grown, so has The Corner Health Center. Doctor Chesler feels that "people have come to trust and appreciate the care they receive at the Center." Anyone interested in The Corner Health Center or its programs is encouraged to stop by for a tour or to talk with the staff. (47 N. Huron St., Ypsilanti, MI 48197 313/484-3600) □

Robert M. Leitch, MD: 30 years with MSMS

By Judy Marr, Editor

The day he was elected chairman of the MSMS Board (then called Council), Battle Creek family physician Robert M. Leitch, MD, faced a crisis.

It was 1969, and Medicaid was just getting off the ground. Governor Milliken had addressed the MSMS House of Delegates, describing the new insurance program and the state's plan for compulsory physician participation.

"The delegates left on a very divisive note," recalls Doctor Leitch, who has just retired after 30 years of leadership service to MSMS. "Some felt the doctors were going to strike."

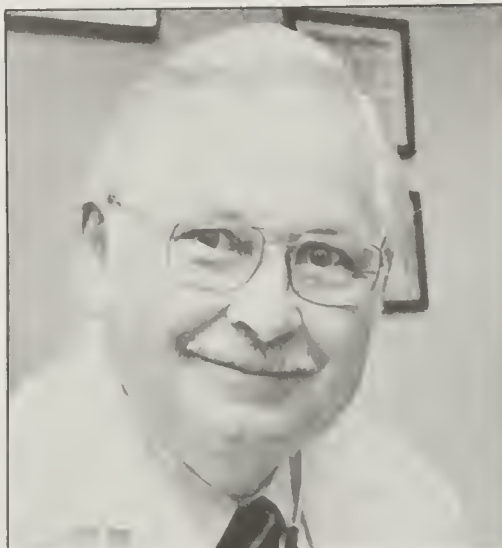
The new chairman called a special meeting of the Council a few days later, established the Medicaid Liaison Committee, enlisted the governor's aid, and won agreement of all parties.

"We eventually solved the problem fairly satisfactorily, and avoided any strikes or other such general confrontation," recounts Doctor Leitch.

However, prominent Detroit-area MSMS member Sidney Adler, MD, objected to the way Doctor Leitch had personally called the Governor asking for aid.

"That's not the way you do it; you don't call up the governor," Sidney told me," says Doctor Leitch. "He said, 'When I want to talk to the governor, I call Max Fisher, and the governor calls me'".

Doctor Leitch says he apolo-



Doctor Leitch

gized for his direct approach, but explained he thought it was the most expedient, and that it was the way he did things.

The advent of Medicaid is one of Doctor Leitch's memories of "pivotal moments" in MSMS history.

The urban physician's advice to the outstate leader was a fairly typical situation in Doctor Leitch's earlier decades of MSMS activity, he says. In fact, he lists the improvement in cooperation between Detroit-area and outstate physicians as one of the major MSMS changes he has witnessed.

"There used to be a lot of animosity," he says. "In fact, Wayne County never had a Council chairman for 30 years. We just couldn't get one elected. Some of those people were pretty overbearing, I guess, and the 'country boys' didn't enjoy that very much."

He credits the improved co-

operation to a change in the attitude of urban physicians and a greater sophistication on the part of the outstate physicians.

Doctor Leitch, with his direct, forthright manner, and white-haired, kindly demeanor, has been the MSMS version of "Doctor Welby" for three decades. He has been in on all the major MSMS developments since he first was elected an alternate delegate in 1957.

He served as MSMS president in 1976-77, in the height of that decade's malpractice insurance crisis, and led MSMS efforts to found the Michigan Physicians Mutual Liability Company. He has served as the original vice president, then president of MPMLC, which was designed to ease the physicians' problems in obtaining coverage.

He served as MSMS secretary from 1978 to his retirement at the 1988 House of Delegates meeting following the latest of several heart attacks. Today he may be less robust physically, but his insights and keen mind continue an invaluable resource for MSMS leaders.

One of the biggest challenges to physicians today, he assesses, is dealing with the cost of medical care. He predicts more government encroachment in the medical reimbursement system.

"The cost of medical care and the insurance to cover it have become prohibitive for the average citizen," he says. This has caused

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LEITCH/Continued

the government to step more into the reimbursement process, to dictate what can be done, and who does it.

"I don't think there is any doubt we will get some form of socialized medicine eventually," he says. "We stalled it off in the late 40s and early 50s, but it has come in gradually one way or another, anyway."

The impact of a more socialized system already is evident, he notes.

"The applications for medical school are way down," he says. "Doctors' children are opting not to be physicians. The pressures and changes make it less appealing."

What physicians can do to meet these challenges, according to Doctor Leitch: "Practice the best, most efficient medicine they can, and try to hold down costs as much as they can," he says, simply. "They must be as attentive and sympathetic to their patients as they can be."

"A lot of doctors have become entrepreneurs, developing labs and clinics and all sorts of gimmicks to enhance their income. It may be they'd be better off devoting their time to patient care."

In 1984, Doctor Leitch published an article in *Medical Economics* on "six basic steps to avoiding a malpractice suit." As MPMLC president and chairman of the board, he had some knowledge of the subject.

In the article, Doctor Leitch

"I don't think there is any doubt we will get socialized medicine eventually..."

counseled physicians to practice six Cs of prevention: Concentration on the task at hand, Concern for patients, Communication with patients, the legally-vital type of communication called Consent, Consultation with more experienced colleagues, and Courage—to fight frivolous cases, and to admit mistakes rather than commit to costly, hopeless lawsuit battles.

Doctor Leitch says he would give the same advice today. He adds that we also need to increase public awareness of the effect of the liability situation on the cost of medical care.

"But extreme care on the part of the doctor in treating patients will go a long way to decrease the number of lawsuits," he emphasizes.

In fact, "there is no question there is considerably less malpractice perpetrated by physicians than occurred 10 to 15 years ago," reports Doctor Leitch, who continues to consult with MPMLC in his status as president emeritus.

"Doctors are much more cognizant of the situation, and are taking steps to avoid the pitfalls leading to lawsuits," he says.

In addition, he notes, the number of frivolous claims filed against physicians is down considerably. He attributes part of the drop to the sanctions imposed by 1986 legislation.

He also says experience has made lawyers more sophisticated.

"The big, highly-specialized medical malpractice plaintiff firms are very choosy about what cases they take. If they don't think they have a good chance of winning, they won't take a case."

A pet project of Doctor Leitch's is the recruitment, through MPMLC, of physicians to serve on the new medical malpractice mediation panels established by the 1986 liability reform legislation. Doctor Leitch is looking at fellow retired physicians as a potential pool of recruits.

"I'm hoping we can get that program off the ground," he says.

He's seen MSMS become more activist over the years, he observes, and has watched the scope of its activities increase.

"The involvement of the physician population is greater than it used to be," he says, "as more seem interested in medical poli-

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LEITCH/Continued

tics and MSMS activities.”

MSMS must continue to improve physician participation, he emphasizes, and be as strong as possible a physician advocate.

“It’s not just to the physicians’ advantage, but also in the best interests of the patient,” he explains. “The more they know what’s going on, the more they are likely to be supportive,” he continues. “And the more input we can get from a larger variety of doctors, the stronger the society will be.”

He remembers:

Former MSMS Speaker and President James J. Lightbody, MD — “He had a great sense of humor but got the job done.”

Former MSMS President and Secretary Kenneth H. Johnson, MD — “In his many different roles in his years of service, he was a vital member of the hierarchy of organized medicine.”

Former AMA and MSMS President John J. Coury, MD — “The man who has accomplished the most on the national level. We were very closely associated in the early days.”

Former MSMS Treasurer and President Ernest P. Griffin, MD — “He made a great contribution, particularly in the financial arena.”

And others more recent— Frank B. Walker, MD; Robert E. Paxton, MD, Carl A. Gagliardi, MD, and Frederick W. Bryant, MD — “They all have made important contributions.”

“I’ve greatly enjoyed my 30 years or so of active participation in MSMS,” he says. “The memories and contacts both with Michigan physicians and others nationwide have been a great source of pleasure.

“It’s been a lot of fun, and I’ve had a lot of satisfaction in seeing some things accomplished.” □

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Health care insurance a key concern for Sen. John Kelly

By Chad Munger

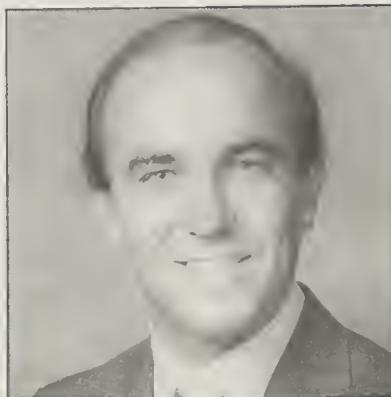
The term "maverick" often is used to describe Senator John Kelly; it's a label to which he might not object. For this young Irishman from Detroit, a little individuality in the political "equation" is what makes democracy an adventure.

Senator Kelly (D-Detroit) describes political power as a fluid commodity, one which is constantly reorienting itself in relationship to the people, the issues and the day of the week.

"Everyday I walk into the chamber there is an new adventure waiting. I never know what I'm going to find. How these people (legislators) were treated on their way up, how the newspapers handled them, the weather—all those things have an impact upon decisions. It's amazing to watch how these things change public policy and affect millions of peoples' lives."

This outlook on politics is not the result of following any particular role model. As Sen. Kelly puts it, "I'm not really into hero-worship." Instead, he relies on his knowledge of the Constitution to give him political direction. "It comes down to watching the way the Constitution works and seeing the nuances and opportunities it gives people."

Having never held public office before his 1978 election to the state senate, Sen. Kelly used his extensive academic experience to prepare himself for political life. He earned a law degree from the Detroit College of Law and is a



Senator Kelly

"Right now there is an incentive to be indigent in Michigan."

PhD candidate in political science at Wayne State University.

Physicians play a prominent role in the political life of this senator; the district from which he hails has a higher percentage of medical doctors than does any other senate or house district in Michigan.

Sen. Kelly cites the need for a new type of health care insurance as "the most pressing social issue in Detroit." He is particularly concerned about the inequality of opportunity between the working and non-working poor to receive health care.

"Right now there is an incentive to be indigent in Michigan. You have the best insurance

available and you don't have to pay for it."

In response to this issue he will introduce a package of bills in the fall of 1988 that, if adopted, will create a universal health care program.

The package would establish a program to be financed by the state and the employers and employees of firms with 10 or more workers. The Medicaid program would be eliminated and its former recipients incorporated into the program. Unlike the current system, Sen. Kelly's proposal would require recipients to make and keep appointments, have co-pays and deductibles. "If they don't meet these requirements, they will be penalized. Sanctions will be taken against them," said Sen. Kelly. "I think what this bill will do is put non-working and working poor on the same plank, with the same rights to, and responsibilities for, participation in a health care system."

Physician constituents from the first district have not let the issue of licensure escape his attention.

"It's a double-edged sword," Sen. Kelly states.

"Medical technology has advanced to the point where there are a whole range of subprofessionals which need to be, but are not, licensed in Michigan. By the same token, we need to redirect the scope of practice." He suggests making licensure more accessible and then using tight

Continued on page 543

Announcing a new benefit beyond price alone.

Advanced Formula

Mytrex[®]

(nystatin-triamcinolone
acetronide)

New — fragrance-free formula

- ☐ Avoids the #1 irritant in cutaneous reactions¹
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...and still economical

Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



SAVAGE LABORATORIES
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Mytrex[®] CREAM AND OINTMENT, USP

(nystatin-triamcinolone acetonide)

Brief Summary of Prescribing Information

For Dermatologic Use Only
Not for Ophthalmic Use

INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see **DOSAGE AND ADMINISTRATION**). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see **PRECAUTIONS, Pediatric Use**). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see **DOSAGE AND ADMINISTRATION**).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. *Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio.* HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX[®] (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX[®] is usually applied to the affected area twice daily in the morning and evening. MYTREX[®] should be discontinued if symptoms persist after 25 days of therapy. (See **PRECAUTIONS, Laboratory Tests**). MYTREX[®] should not be used with occlusive dressings.

Caution: Federal law prohibits dispensing without prescription.



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IN MY OPINION/Continued

being aware that some very expensive therapies may be precluded by policies established at a different level that reflect finite allocations for health care. Some options for additional care (especially those very costly and/or marginally effective) would simply not be available.

The physician must be able to advocate for the patient, but cannot be held responsible legally for not trying every conceivable, valiant and heroic therapy when constrained by prudent and just policies. A very expensive gesture to one person which has little hope of lasting success should not be seen as a replacement for providing effective, inexpensive care for others.

Policies must be made which will use resources wisely and never delude the public into thinking all things are possible. Following prudent policies is even more difficult than making them. The TV coverage of anguished parents or presidents requesting donations when established policies deny coverage has been viewed by most of us.

Decisions about how best to care for the 20 percent of the population that is uninsured or underinsured require input from all segments of our society. Certainly those of us actually giving the care need to be very active in this process. I earnestly request your ideas and thoughts. □

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KELLY/Continued

regulation after licensing as the first step in the resolution of this problem.

We need to get rid of anti-trust suits against peer review organizations to effectively remove unqualified professionals from the medical field, states Sen. Kelly. The establishment of "mega-boards" to replace existing review boards is his solution to this problem. Each board would be composed of a cognate of professionals which would have no interest in restraint-of-trade litigation.

Over the course of his three terms as senator, Sen. Kelly's legislative assignments have taken on an international flavor. As former chairman of the Banking Committee, he was appointed envoy to the Peoples Republic of China. In his three visits there Kelly has helped the Chinese with a number of economic development projects, including creation of a new model of tourism.

When not in session or on assignment abroad, Sen. Kelly spends much of his time as an instructor of political science at Mercy College, The University of Detroit and Wayne State University.

During the very little time Sen. Kelly finds to spend outside of his professional commitments, he might be found working with a political prisoner or an immigrant, through Amnesty International. He also is active in the

"We need to get rid of anti-trust suits against peer review organizations."

Irish community, sponsoring an annual Detroit parade, complete with authentic Irish step dancers and music.

On those days when being an

ambitious legislator has been productive, you might find Sen. Kelly contemplating a different sort of run—one to the governor's office. □



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UPDATE IN '88: From Basics To Lasers

Michigan State Medical Society offers a program which takes you all the way from the clinical basics to the highly-sophisticated and varied uses of lasers in medicine.

At the Annual Scientific Meeting, Michigan physicians may accumulate a total of 19 Category I credit hours, nearly four-fifths of the required total for the year. Don't miss this CME opportunity.



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn



Update in '88

Annual Scientific Meeting offers a wealth of courses

By Joan Stryker, MD, Chairman
MSMS Annual Scientific Meeting

As chairman of the 1988 MSMS Annual Scientific Meeting, I am pleased to invite all MSMS members to this most distinguished of continuing medical education events.

It is with great pleasure and pride that I have headed the planning for the November 8 to 10 meeting at the Hyatt Regency Dearborn. It is an honor to follow in the tradition of such accomplished former chairmen as Rudi Ansbacher, MD; C. Edward Cotton, MD; Frank Cox, MD; Samuel M. McMahon, MD; David R. Rovner, MD, and Robert F. Wilson, MD.

The theme of the meeting this year is "Update in '88."

The Planning Committee has endeavored to provide MSMS members with a program which takes you all the way from the clinical basics to the highly-sophisticated and varied uses of lasers in medicine.

We are providing a wealth of courses focusing on children, the family and the elderly, which should be of special appeal to family physicians. At the other end of the spectrum, we have a full day's offerings in the use of lasers, which ends by detailing their application to six specialties.

A new offering in 1988 will be the first-ever Annual Scientific Meeting plenary session. Planned at 7:15 a.m. Wednesday, prior to the convening of regular classes, the session will present nationally-known AIDS expert James Curran, MD, of the Centers for Disease Control.

Doctor Curran, who is a Michigan native, will describe where the Michigan experience with AIDS fits into the national perspective, and will discuss treatment programs the CDC is finding particularly efficacious.



This plenary session is free to all attending the meeting, and will offer one Category I credit hour.

Speaking of credit hours, I would like to emphasize that through attendance at this one MSMS meeting, Michigan physicians may accumulate a total of 19 Category I credit hours, nearly four-fifths of the required total for the year.

The price is reasonable, the location convenient and easy to reach, the facilities excellent. In all, the meeting is an excellent continuing medical education opportunity.

Other features of this year's meeting I am proud to share with you include the ever-popular poster presentations. This year the planning committee has chosen 20 presentations from those submitted for review.

The posters will be on display in the corridor outside the exhibit hall, and authors will be present to discuss their findings. Judging of the posters will take place the first day of the meeting, so that viewers may share the winners' success throughout the meeting.

Among the variety of special events planned surrounding the Annual Scientific Meeting will be the receptions sponsored by the alumni associations of the medical schools at Michigan State University, The University of Michigan and Wayne State University.

Continue reading the following pages, and you will discover further news about the meeting, as well as a tear-out registration form. In addition, please watch for the October *Michigan Medicine* "convention special" issue, which will provide complete details.

I look forward to greeting each of you personally at the meeting. Come to Dearborn and receive your own "Update in '88!"

Capsule Schedule of Annual Scientific Meeting



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn

TUESDAY, NOVEMBER 8

7:30 AM

Great Lakes Exhibit Center Open

Registration

8:30 AM

Concurrent Scientific Courses (run until Noon)

- Hyperlipidemia
- Coronary Syndromes
- Arthritis
- Basic Cardiac Life Support
- Ob/Gyn Pathology
- Hypertension
- Perioperative Problems
- Venous Disorders
- Sinus Disease

Clinical Poster Display (all day)

12 Noon

Luncheon for All Registrants

Michigan Occupational Medical Association
(Luncheon/Board Meeting)

1:00 PM

Board Meeting and Luncheon

Michigan Chapter of American Academy of Pediatrics

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- Children with Chronic Illness
- Neuroradiologic Applications of MRI
- Clinical Toxicology
- Hematology
- Family Counseling Skills
- Neuromuscular Diseases
- Physicians Recovery Network
- Pulmonary Infections
- Rehabilitation of the Elderly

6:00 PM

Reception/Dinner/Program

Michigan Occupational Medicine Association,
Detroit Michigan

Occupational Health Nurses

Association and the Michigan Industrial
Hygiene Society

Reception

MSMS ASM Planning Committee

WEDNESDAY, NOVEMBER 9

7:00 AM

"Early Bird" Plenary Session on AIDS

Hubbard Ballroom (Coffee & Rolls included)

7:30 AM

Great Lakes Exhibit Center Open

Registration

8:30 AM

Clinical Poster Display (all day)

Concurrent Scientific Courses (run until Noon)

- Arterial Blood Gases
- Acute Visual Problems
- Basic Cardiac Life Support
- Cancer Prevention and Detection
- Drug Testing
- Diagnostic Ultrasound
- Estrogen Replacement Therapy
- Pregnancy in Diabetes Mellitus
- The Handicapped Patient

9:00 AM

Board Meeting/Luncheon

Michigan Allergy Society

12 Noon

Lunch for All Registrants

Luncheon

Specialty Society Presidents

Luncheon

Sponsored by MSMS Committee on Concerns
of Women Physicians

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- AIDS Update
- Allergy and Asthma
- Back Pain
- Pediatric Problems
- Otolaryngologic Problems
- Controversies in Anesthesiology
- Dermatology Update
- Radiology
- Physician's Office Laboratory
- Violence in the Family

6:00 PM

Reception/Dinner/Program

Michigan Otolaryngological Society

Reception/Cash Bar

Michigan State University

College of Human Medicine

Open House

University of Michigan Medical School

Reception

Wayne State University Medical Alumni

THURSDAY, NOVEMBER 10

7:30 AM

Great Lakes Exhibit Center Open

Registration

8:30 AM

Concurrent Scientific Courses (run until Noon)

- The Paralyzed Face
- Basic Cardiac Life Support
- Cardiovascular Disease in Women
- Sleep Apnea
- Gastrointestinal Endoscopy
- Lasers (Part I)
- Nephrologic Problems
- The Suicidal Patient

12 Noon

Lunch for All Registrants

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- Urinary Incontinence
- Plastic Surgical Research
- Financing Long-Term Care
- Lasers (Part II)
- Gastrointestinal Tract
- Nuclear Medicine
- Thyroid Patient
- Pediatric Emergencies
- Sports Medicine
- Colorectal Surgery

5:30 PM

Board Meeting/Reception/Dinner/Program

Michigan Academy of Physical Medicine & Rehabilitation

6:30 PM

Dinner/Program

Michigan Society of Colon & Rectal Surgeons

Schedule of Special Events

■ Clinical Poster Displays

(all day)

Tuesday and Wednesday, November 8-9

■ "Early Bird" Plenary Session on AIDS

with CDC expert from Atlanta

(Coffee & Rolls included)

Wednesday, November 9 at 7:15 a.m.

■ Michigan Academy of Physical Medicine & Rehabilitation

Board Meeting/Reception/Dinner/Program

Thursday, November 10 at 5:30 p.m.

■ Michigan Allergy Society

Wednesday, November 9

Board Meeting at 9:00 a.m.

Luncheon at 12 Noon

■ Michigan Chapter of American Academy of Pediatrics

Board Meeting/Luncheon

Tuesday, November 8 at 1:00 p.m.

■ Michigan Occupational Medical Association

Board Meeting/Luncheon

Tuesday, November 8 at 12 Noon

■ Michigan Occupational Medical Association, Detroit Michigan Occupational Health Nurses Association and the Michigan Industrial Hygiene Society

Reception/Dinner/Program

Tuesday, November 8 at 6:00 p.m.

■ Michigan Otolaryngological Society

Reception/Dinner/Program

Wednesday, November 9 at 6:00 p.m.

■ Michigan Society of Colon & Rectal Surgeons

Reception/Dinner/Program

Thursday, November 10 at 6:30 p.m.

■ Michigan State University College of Human Medicine

Reception/Cash Bar

Wednesday, November 9 at 6:00 p.m.

■ MSMS ASM Planning Committee

Reception/Buffer

Tuesday, November 8 at 6:00 p.m.

■ MSMS Committee on Concerns of Women Physicians

Luncheon

Wednesday, November 9 at 12 Noon

■ Specialty Society Presidents

Luncheon

Wednesday, November 9 at 12 Noon

■ University of Michigan Medical School

Open House

Wednesday, November 9 at 6:00 p.m.

■ Wayne State University Medical Alumni

Reception

Wednesday, November 9 at 6:00 p.m.

Plan to Visit These Firms' Exhibits



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn

There are 70 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting November 8-10 at the Hyatt Regency Dearborn.

The trained professional representatives of 70 firms will be there to discuss the details of their products and services in a relaxed atmosphere.

The exhibit hall is an important part of the ASM and is the site of registration for all courses and special events. In addition, the deli luncheons and refreshments during breaks are all set up in the exhibit area.

To help you plan, exhibitors are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

■ PHARMACEUTICALS

Boehringer Ingelheim Pharmaceuticals, Inc.
Glaxo, Inc.
Janssen Pharmaceuticals
Mead Johnson Laboratories
Mead Johnson Nutritional Division
Merck Sharp & Dohme
Parke-Davis
Reed & Carnrick
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Syntex Laboratories, Inc.
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■ CLINICAL LABORATORIES

Advance Medical/Met Path
CBC Laboratory Service, Inc.
Health Care Clinical Laboratory
National Health Laboratories, Inc.
Oakland Diagnostic Laboratory
Perry Health Net

■ IN-OFFICE EQUIPMENT AND SUPPORT

Brentwood Instruments
Cellular One
Firestone X-Ray Corporation
Medical Staff Placement
Vista Medical Systems, Inc.
Wolverine X-Ray

■ PATIENT HOME CARE

Better Health Products
Caremark Homecare
Gerber Products Company
Medical Home Care Pharmacy
Metro Rehabilitation Services, Inc.
Theracom, Inc.

■ COMPUTERS/COMPUTER SERVICES

Bennethum Computer Systems
Colonial Valley Software, Inc.

Diversitec-Automated Input
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MAI Basic Four
Management Systems Engineering, Inc.
Medical Billing Service
Phoenix Management Group
Professional On-Line Computer, Inc.
Professional Practice Sales, Inc.
Scientific Data Management, Inc.

■ EDUCATIONAL RESOURCES

Encyclopaedia Britannica USA
J.B. Lippincott Company
W.B. Saunders

■ PROTECTION

AMA Advisors
Blue Cross and Blue Shield of Michigan
Comerica, Incorporated
Disability Determination Service
MPMLC/SCMS (Physicians Liability Insurance/Related Products)
Michigan National Bank
Physicians Insurance Company of Michigan
Physician Service Group, Inc.
Professional Asset Management, Inc.
Retirement Plan Consulting Group
Thomson-McKinnon Securities

■ CAREER

Henry Ford Westside Medical Centers
U.S. Air Force Recruiting Service
U.S. Army Health Professional Support Agency
W.A. Foote Memorial Hospital, Inc.

■ OTHER EXHIBITORS

Havenwyck Hospital
Henry Ford Hospital
The Oxford Institute
University of Michigan Medical Center M-Labs
University of Michigan Medical Center M-Line
University of Michigan Medical Center

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Registration Form

for Category I CME Courses



1988 MSMS ANNUAL
SCIENTIFIC MEETING
November 8, 9, & 10
Hyatt Regency, Dearborn

Name _____
(first) (initial) (last)
Address _____
City _____ State _____ Zip _____
County _____ Phone () _____
MSMS Member: Yes ☐ No ☐ Resident ☐ Specialty _____ Other _____

Physicians must make their own hotel reservations prior to 10/13/88 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

CHOOSING YOUR COURSES

Please check the courses you wish to attend. In each case, **please indicate a second choice** should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

TUESDAY MORNING, NOVEMBER 8 (8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ A Practical Approach to Hyperlipidemia
- ☐ Acute Coronary Syndromes: Mechanical & Medical Interventions
- ☐ Arthritis in the Office
- ☐ Basic Cardiac Life Support
- ☐ Current Concepts in Gynecological and Obstetrical Pathology
- ☐ Hypertension — Current Therapeutic Update
- ☐ Perioperative Problems for the Primary Care Physician
- ☐ Venous Disorders: Current Management
- ☐ Wiping Out Sinus Disease

WEDNESDAY MORNING, NOVEMBER 9 (7:15-8:15 AM)

_____ "Early Bird" Plenary Session on AIDS
(continental breakfast included) No Fee

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ A Practicum on Arterial Blood Gases
- ☐ Acute Visual Problems
- ☐ Basic Cardiac Life Support
- ☐ Cancer Prevention and Detection for Primary Care Physicians
- ☐ Current Status of Drug Testing
- ☐ Diagnostic Ultrasound in Modern Medicine
- ☐ Estrogen Replacement Therapy
- ☐ Planning For Pregnancy in Diabetes Mellitus
- ☐ The Handicapped Patient in Society and Private Practice

THURSDAY MORNING, NOVEMBER 10 (8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Animation of the Paralyzed Face
- ☐ Basic Cardiac Life Support
- ☐ Cardiovascular Disease in Women: The Pill, and Estrogen Replacement
- ☐ Current Concepts in Sleep Apnea
- ☐ Gastrointestinal Endoscopy and the Generalist
- ☐ Lasers: Today's Medical Tools (Part I)
- ☐ Practical Approach to Common Nephrologic Problems
- ☐ The Suicidal Patient and the Primary Care Physician

Lunch will be provided at no extra charge for paid registrants. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

Tuesday lunch ☐

Wednesday lunch ☐

Thursday lunch ☐

TUESDAY AFTERNOON, NOVEMBER 8 (1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Children with Chronic Illness: Shared Needs and Concerns
- ☐ Clinical Neuroradiologic Applications of Magnetic Resonance Imaging
- ☐ Clinical Toxicology for the Front Line Physician
- ☐ Common Problems in Hematology
- ☐ Family Counseling Skills for Office Practice
- ☐ Neuromuscular Diseases
- ☐ Physicians Recovery Network: Help a Friend
- ☐ Pulmonary Infections
- ☐ Rehabilitation of the Elderly: Keeping Older Patients on Their Feet

WEDNESDAY AFTERNOON, NOVEMBER 9 (1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ AIDS Update
- ☐ Allergy and Asthma Update
- ☐ Back Pain: Returning to Work
- ☐ Common Office Pediatric Problems
- ☐ Common Otolaryngologic Problems in Children
- ☐ Current Controversies in Anesthesiology
- ☐ Dermatology Update in '88
- ☐ Radiology for Clinicians
- ☐ The Physician's Office Laboratory in 1988
- ☐ Violence in the Family

THURSDAY AFTERNOON, NOVEMBER 10 (1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Advances in Diagnosis and Treatment of Urinary Incontinence
- ☐ Clinical Correlation of Plastic Surgical Research
- ☐ Financing Long-Term Care: Impact on Patients and Providers
- ☐ Lasers: Today's Medical Tools (Part II)
- ☐ Motility and Other Functional Disorders of the Gastrointestinal Tract
- ☐ New Frontiers in Nuclear Medicine
- ☐ Optimal Approach to the Thyroid Patient
- ☐ Pediatric Emergencies
- ☐ Sports Medicine for Primary Care Physicians
- ☐ Update in Colorectal Surgery

YOUR PAYMENT

Multiply total number of half-day courses by appropriate fee:

MSMS Members: \$25 for each half-day course	_____ x \$25 (members)	= \$_____
MSMS Members with "retired status" pay half	_____ x \$12 (retired)	= \$_____
Non-members: \$50 for each half-day course	_____ x \$50 (non-members)	= \$_____
Residents: \$15 for each half-day course	_____ x \$15 (residents)	= \$_____
Students: NO CHARGE — Limited Enrollment	_____ x \$0 (students)	= \$_____
Lunch tickets may be purchased)	_____ x \$10 (student lunch)	= \$_____
	TOTAL	= \$_____

Make checks payable to Michigan State Medical Society and mail to MSMS, Box 950, East Lansing, MI 48826-0950

Send this entire page with your check.

Confirmation of your reservation will be sent to you. Your course materials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk in the Great Lakes Exhibit Center.

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U-M Dean: "It's an exciting and challenging time."

By Judy Marr, Editor

Editor's note: The following is the first in a series of profiles of medical school deans in Michigan.

"This medical center does not view itself as an ivory tower."

Making that point emphatically, University of Michigan Medical School Dean Joseph E. Johnson III, MD, elaborates:

"In the past there has been too much of a perception of the University Medical Center as an isolated entity. That is certainly less appropriate today than ever before. We need to work increasingly with practicing physicians and organized medicine to meet our mutual challenges."

The former Bowman Gray chairman of medicine says he was attracted to U-M because of the medical school's "long tradition of excellence," its record of "many important first contributions in medicine," and because the U-M Medical Center is in a growth phase.

Dean Johnson describes several challenges to the U-M Medical School, the University Medical Center and to himself as dean, personally:

1) Developing medical students' judgmental, problem-solving skills, while continuing to ensure they develop basic medical care skills.

2) Developing a research-intensive faculty that also concentrates on clinical patient care.

3) Gaining experience for medical center faculty and staff,



Dean Johnson

"... There has been too much of a perception of the University Medical Center as an isolated entity."

and educating students and residents, in new "managed-care" delivery systems.

4) Continuing to strive for top-quality students in the face of fewer Michigan applicants for medical school positions.

5) Developing better models of teaching ambulatory care as the University Hospital becomes more intensive-care oriented and less opportunity is provided for teaching basic skills.

Dean Johnson's challenges might seem overwhelming. But the primary emotions the man exhibits are pride and excitement.

"If I sound like I'm bragging, I apologize," he says. "But there are a tremendous number of exciting opportunities in all areas."

Research. "We continue to encourage the research activities of our faculty," he says, "with those activities focused on 'centers of excellence.'" These include the U-M cancer, geriatric, and substance abuse centers, recently re-emphasized, as well as the transplantation unit, diabetes, neuro-

sciences, and hearing centers.

"Our total funded, supported research increased 22 percent this year, and continues to rise dramatically, at a time when support is leveling off or decreasing in other places," he says.

Medical education. The U-M Medical School is making new initiatives in its curriculum, including a shift to more computer-assisted instruction. One example is the use of imaging techniques in gross anatomy studies.

Small-group discussions and self-learning will replace former "spoon-feeding" techniques, says Dean Johnson, with the emphasis more on problem-solving and less on classic memorization.

"The knowledge explosion is contributing so much data, it is impossible for any student to know all," he continues. "We have to work on ways for the student to develop basic skills and judgmental abilities, and to increase the efficiency by which the student can access data."

Patient care activities. The

focus of all such activities at the University of Michigan is the new University Hospital, the state-of-the-art facility dominating the medical center campus.

Dean Johnson reports the university is working to make clinical care more efficient, more personalized, and easier for patients to access. This effort includes improving contacts with the university's state-wide network of referring physicians.

The U-M has a three-pronged effort underway to improve its relationship with referring physicians. One prong is an upgrade to the two-year-old M-Line, a toll-free number which physicians may use 24 hours a day to obtain information and referrals for patients.

The newest wrinkle in the M-Line program is establishment of an advocate, called a "consultation guide," for the caller. This person answers the physician's call, then stays with the caller until he or she has reached the desired contact.

The U-M also has conducted focus group studies with practicing physicians, to develop ideas for improving its referral system. And, the university is making a major effort to improve the flow of patient information back to referring physicians.

Managed care systems. "Our purpose is not to become a major national force in this area," Dean Johnson explains. "We need some experience. We need to figure the most effective ways to educate our students and resi-

dents to use such systems.

"Managed care systems clearly are going to be an important part of care given, so we are using our M-Care program as a model."

Dean Johnson is concerned with a drop in numbers of Michigan students applying for acceptance in medical schools. The drop parallels the national rate of

"The pool of Michigan applicants still is big enough that we've been able to successfully compete for the quality students."

decline from the former 3.5 applicants for every available position 40 years ago, to the current 1.7 applicants per position.

"We haven't seen any evidence yet of a decline in the quality of students actually accepted," he says. "The pool of Michigan applicants still is big enough that we've been able to successfully compete for the quality students."

At the same time, he says, there has been a substantial increase the past five years in the number of out-of-state students

applying to the University of Michigan Medical School. Those numbers are approaching 3,000 applicants for the 200 available positions per U-M class.

The drop in Michigan applicants concerns Dean Johnson, because the medical school is committed to giving a major opportunity to Michigan residents and to developing Michigan physicians. About 80 percent of U-M Medical School students are Michigan residents.

He attributes the decline in Michigan applicants to a number of factors which are making an impact nationally—the more complicated and less attractive medical practice environment, the high debts medical students now incur by graduation, the malpractice insurance climate and changing reimbursement patterns.

"The paradox is that these complications come at a time in the history of medicine when the opportunity to practice effectively—to really do something helpful for patients—is at an all-time high."

The shift toward group practices has enabled more physicians to lead more comfortable lives, without the requirement of such long hours and constant on-call problems.

"This is healthy," he says. "I believe many of these changes will be viewed in the long run as beneficial."

In many ways medicine is

Continued on next page

JOHNSON/Continued

more attractive today, says Dean Johnson. "There still are tremendous opportunities to have a very satisfactory career in medicine."

Undoubtedly, therefore, a turn around in the ratio of in- to out-state applicants is ahead, he reasons.

"I think it will reverse itself. I am not terribly pessimistic."

Dean Johnson also is concerned about medical education funding. Two-thirds of U-M medical students require financial aid, and over one-half graduate with debts in excess of \$30,000.

He sees the debt burden as one factor in U-M students' tendencies to go into surgical specialties, where potential income is higher.

"The real problem is that students from less-affluent backgrounds are more likely to be turned off by the prospect of big debts," he says. "We have to figure out ways to lighten the burden."

The U-M goal, he says, is to make certain that no student is unable to enter medical school, or to finish medical school, because of financial concerns.

He proudly emphasizes that U-M's is one of the leading medical schools in the country in terms of its black student enrollment, which measured 12.9 percent of the 1987-88 entering class.

"This has been a major priority in the last few years," he says. "We have increased that percentage from eight percent in the last



University of Michigan Medical Science Research Building I, II, home of the U-M Medical School.

decade."

Dean Johnson sees changes ahead in medical education.

"There is a major shift in the pattern of medical practice toward more ambulatory care. Hospitals are much more intensive care-oriented. Lengths of stay have shortened, patients are sicker, yet undergo more tests and procedures while they are in the hospital.

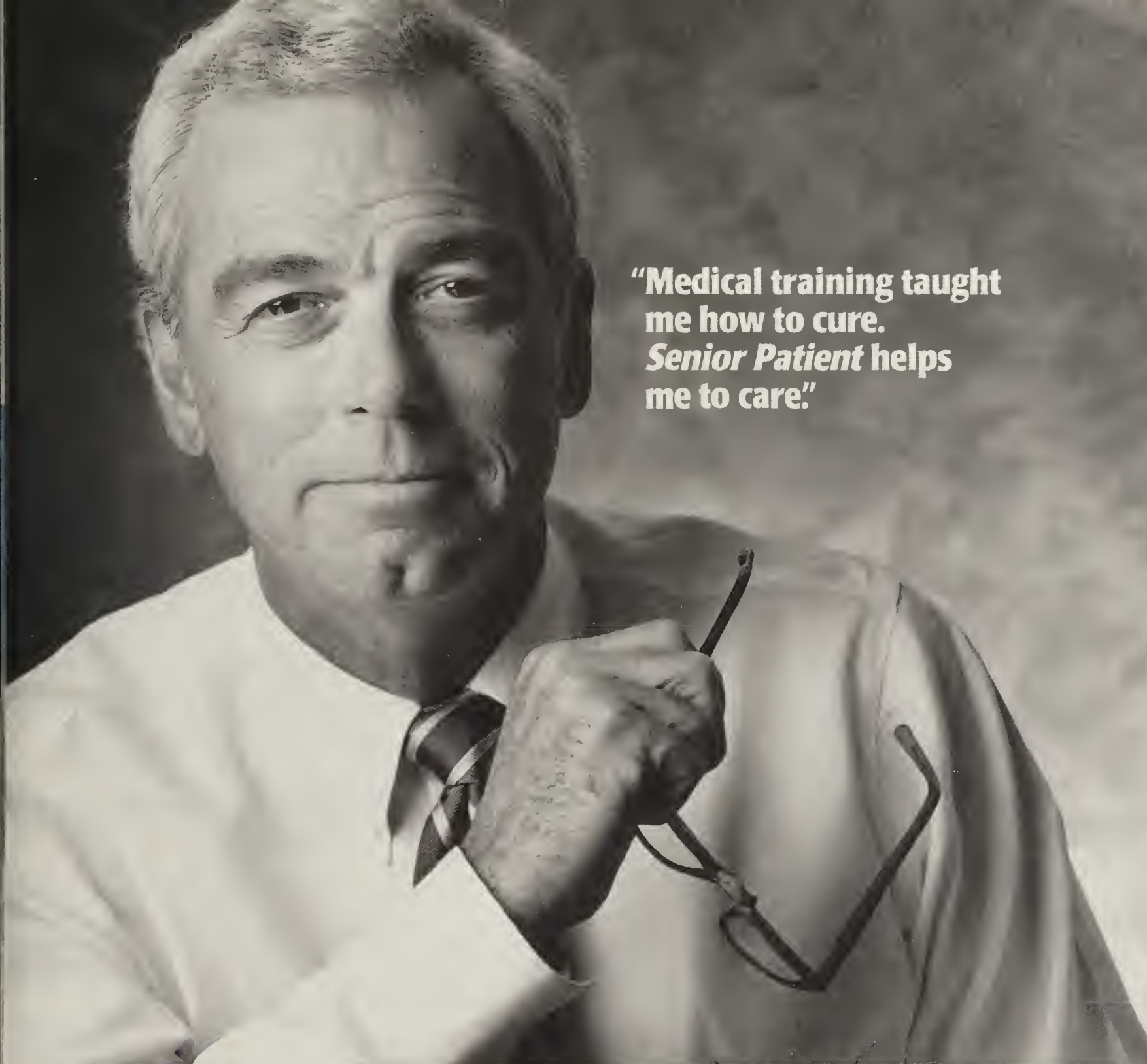
"Therefore it is more difficult to provide basic medical education in the university hospital setting.

"The paradox is that we need physicians who are more effective in the ambulatory care setting,

while at the same time the challenges of their collective inpatients are greater. One of our challenges is to develop better models of teaching ambulatory care."

Dean Johnson also is concerned about a number of areas he calls "orphan subjects." These are such studies as nutrition, preventive medicine, geriatrics, ethics and sexuality.

"U-M has initiatives in each of these areas, but we think they need further development. This is an interesting and challenging time to be in a place like Michigan." □



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U-M fundraising aimed at three major projects

By Judy Marr, Editor

Through your contributions, alumni and friends of the University of Michigan Medical School may play a part in the university's future.

Director of Development Joseph Beyel is concentrating currently on raising funds for three major projects:

- 1) A structure to house the Cancer Center
- 2) A structure to house the Geriatric Center
- 3) Faculty and student aid endowments

The need for an organizational approach to the study and treatment of cancer led to the development of the Cancer Center, officially established May 1, 1986, by the U-M Board of Regents.

"Today, with its own director, staff and identity, the Center serves as a conduit for all Medical Center activities related to cancer," he writes. "Ultimately, we envision the Cancer Center to be housed in its own physical structure, as well."

The University is addressing the need for health and social services to serve our aging population through the establishment of a multi-faceted Center of Excellence in Geriatrics. The U-M currently has more NIH grants in aging than any other institution in the US.

The mission of the Center of Excellence in Geriatrics is to establish a center which will enhance clinically-related biomedical and health services

research in the field of geriatrics, provide educational opportunities for students and trainees, and provide multidisciplinary care for the increasing elderly patient population.

Gifts for the third area will support faculty research or endow physicians at the medical center for their salary and program needs. They also will be applied to the needs of medical

school students at all levels.

"We are not seeking faculty or student gifts for any specific area," says Beyel. "If a person has a particular interest, however, we would love to talk to them about it."

Physicians may send their contributions to the University of Michigan Medical Center Development Office, 506 E. Liberty Street, Ann Arbor 48104. □

U-M updates M-Line program

The University of Michigan recently upgraded its two-year-old M-Line program as part of a three-pronged effort to improve its relationship with referring physicians.

M-Line, a 24-hour toll free information hotline, connects physicians from across the country to U-M medical staff for consultation, to inquire about patients' status or referrals, or for information about clinical and laboratory services.

The newest wrinkle in the M-Line program is establishment of an advocate, called a "consultation guide," for the caller. This person answers the physician's call, then stays with the caller until he or she has reached the desired contact.

M-Line representatives are available to assist callers from 8 a.m. until early evening, Monday

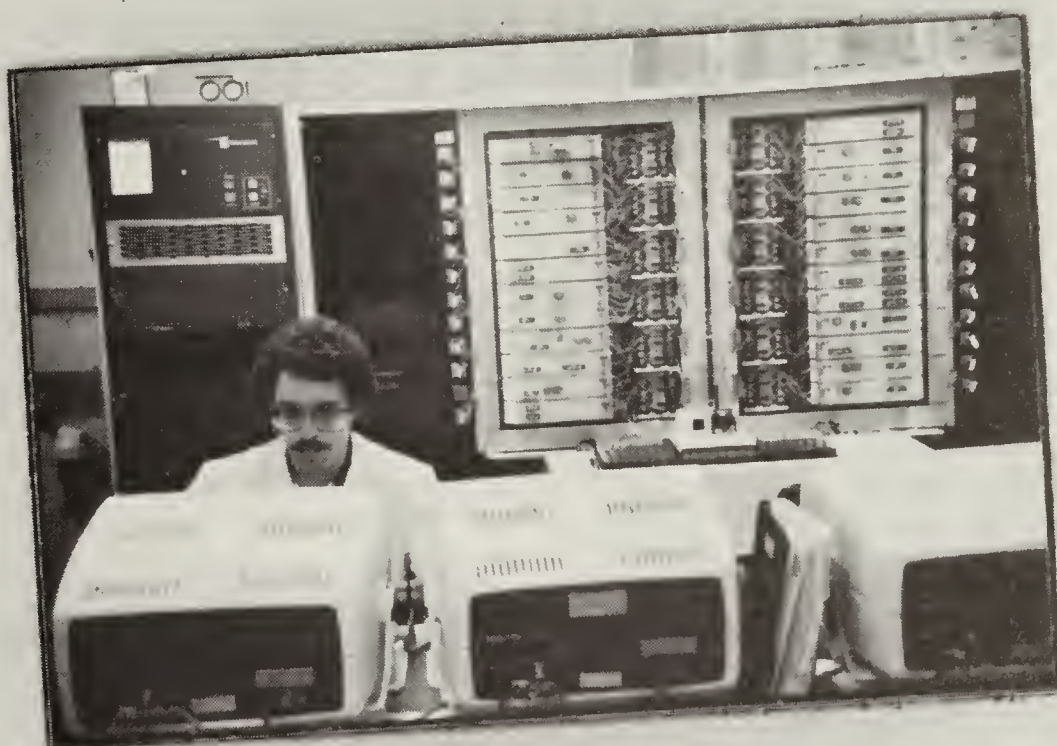
through Friday, and on Saturday morning. Calls received throughout the night will be forwarded to regular hospital information operators who can contact the clinical service caller's request.

M-Line is the first in a series of services the U-M will be offering in its Referring Physician Communication Services.



University of Michigan
Medical Center
Referring Physician
Communication Services
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The Fight Against AIDS: An MSMS Progress Report

By Fred W. Bryant, MD, Chairman
MSMS AIDS Provider Education Task Force

The Michigan State Medical Society (MSMS) formulated its AIDS education plans in April 1985, a project that culminated in a comprehensive report to the Governor in April 1986. That report assessed the scope of the AIDS problem in Michigan and set forth a number of goals and recommendations for effective response. Since that time there has been substantial momentum at both the state and national level for action in the fight against AIDS, and there has been progress, through the efforts of physicians, public health officials, legislators and many others across the spectrum of concerned professionals.

MSMS now has in place those programs required to meet the educational needs of the medical community. As a result of these efforts, at least 7,000 health care providers throughout the state have had access to the best AIDS expertise available in Michigan. We have sponsored workshops, lectures and panel discussions, set up a professional telephone information network, and have made available a variety of printed materials. Clearly, MSMS has taken a leading role in the area of AIDS education.

Our most significant programs were made possible by a contractual agreement with the Michigan Department of Public Health (MDPH). Under the terms of that agreement, MSMS accepted the responsibility to assist in the education of health care professionals about various aspects of AIDS. The MSMS provider education task force was formed in response to that commitment.

The MSMS AIDS Health Care Provider Education Task Force convened in October 1986. The group began the work of implementing the Health Care Provider Education Plan, and saw that plan off the drawing board and in place by February 1987. The task force includes thirty-two representatives professionals drawn from a variety of health care specialties and facilities, and it continues to steer the Society's activities in the AIDS education project. Several important components of the joint MSMS/MDPH AIDS education project have taken shape since 1987.

A statewide **AIDS Speakers Bureau** was established, its purpose to address health care professionals throughout the state. Ninety experts in all specialties, including infectious disease, infection control, psychology, social work and medical ethics, are now available to present educational talks for health care provider groups. In 1988 the number of such groups reached will exceed one hundred with an expected total attendance in the thousands. To arrange for a speaker, groups should contact Lisa M. Strother, Coordinator, AIDS Education Project, MSMS.

A second component to the plan is the **AIDS Telephone Information Network** located at the Wayne County Medical Society. Questions about infection control, testing, and support services can be answered by using the toll-free number. An important aspect of the telephone network is the 35-plus print sources available upon request for patients and professionals. Continual efforts are made to cultivate a comprehensive library of print resources that offer helpful AIDS information. More background on the telephone network can be found in this *Physician's File*.

An important focus of concern in the MSMS program of education is the protection of health care workers. Infection control guidelines developed by a committee of experts have been widely distributed. Large-scale AIDS update meetings continue for specific groups of health care professionals.

Also, in recognition of the unique needs of the health care worker and health care workplace, the MSMS board of directors recently endorsed the "AIDS in the Workplace Guidelines." The Guidelines are located on page 5 of this *Physician's File*.

A significant aspect of the Society's call to assist in halting the spread of AIDS is the development and monitoring of policy initiatives. This *Physician's File* offers an abbreviated version of the 1988 AMA report, "Progress on the Prevention and Control of AIDS," and updates the recommendations endorsed in 1987.

Legislative action on AIDS in Michigan has been a long, involved process. The numerous bills first introduced have been narrowed to the six pending bills listed on page 4. For more information on AIDS legislative activity in Michigan, please contact Mary Anne Ford, Chief, State Government Affairs, at MSMS.

Despite the best efforts of many individuals and organizations, the spread of AIDS continues. As of August 8, 1988 the total number of cases reported in Michigan since 1981 was 767. The Centers for Disease Control (CDC) reported 68,258 adult/adolescent cases in the U.S. as of August 1, 1988. These figures point to the next phase in our overall strategy for continued progress against AIDS. MSMS will concentrate significant energy on the task of public education as the most effective means of halting the spread of AIDS among the citizens of our state.



Telephone Information Network Provides Quick Access to AIDS Information

The MSMS AIDS Information Line has been operating for almost a year now. Word has been circulating all over the state and we have had calls from about half of Michigan's counties from the Upper Peninsula to the Ohio border. Our ability to get specific information from AIDS experts has made the phone line a valuable resource to the callers.

Since opening we have received inquiries from a variety of medical providers - An allergy office wanting to know economical ways to safely dispose of 10,000 needles a month...A rape counselor wanting information on HIV testing...A mid-Michigan doctor planning appropriate care for his first HIV+ patient...A parent needing infection control and support services information so he could bring his son with AIDS back from Georgia...Nursing homes wanting clarification on universal precautions. Many of our calls

have resulted in plans for future MSMS programs on AIDS. The questions we get at the phone line are translating into better information on AIDS for all health care workers in Michigan.

In addition to direct answers to questions, we also have various patient and professional pamphlets available. These have been valuable and popular resources. Below is a list of currently available titles.

The number of calls and variety of topics is constantly increasing. Please inform your colleagues and refer calls to our coordinator, Liz McGough, at (800) 522-0399. In Detroit phone 567-0399. The phone line is open Monday through Friday 9:00 a.m. to 2:00 p.m. An answering machine is available to take messages 24 hours a day.

Resource Materials Available from the Michigan State Medical Society Professional AIDS Information Network 1-800-522-0399

Printed Materials

Patient Information

General Information

Wellness Networks Hotline Cards
Wellness Networks - Flint Cards
AIDS Update, WNI
AIDS Update, MSMS
Surgeon General's Report on AIDS, PHS
What You Should Know About AIDS, PHS
AIDS & Everyone, MDPH
When A Friend Has AIDS, WNI
Straight Talk About Sex and AIDS, SFAF
How To Use A Condom
AIDS in the Workplace, MDPH
You Don't Have to Be White or Gay to get AIDS, SFAF

Specific Topics

Teens & AIDS, Playing it Safe, Am Council of Life Insurance
Should I Have the Test?, WNI

Guidelines for Persons Who Have Developed Antibodies to HTLV-III, WNI
Who To Tell, WNI
Helping With AIDS, WNI
Caring for the AIDS Patient At Home, RC
Infection Precautions for People With AIDS Living in the Community, WNI
Women & AIDS, San Francisco AIDS Foundation
AIDS & Children, Red Cross
Tuberculosis, Am. Lung Assoc.
Alcohol, Drugs & AIDS, SFAF
Can I Cope with my Fear of AIDS, GMHC

Professional Information

Coping With AIDS, NIMH
AIDS Update, Henry Ford Journal of Medicine
Infection Control Guidelines, MSMS
Information on AIDS for the Practicing Physician, AMA
Liquid Chemical Products for Sterilization
Guidelines For The Use of Semen Donor Insemination, Am Fertility Society

SFAF AIDS Educator Catalog
AIDS and the Health Care Worker, Service Employees Union
Medical Answers About AIDS, GMHC
References on Ethics and Testing for HIV
Facts About AIDS for the Dental Team, ADA
Guidelines for Infection Control In The Dental Office and Commercial Lab, ADA
Preventing Transmission of Hepatitis B, AIDS and Herpes in Dentistry, PHS

Video Material

AIDS: Everything You And Your Family Need to Know, HBO
AIDS: Protection for Housekeeping Staff
AIDS: Protection for Laboratory Staff
Management of AIDS Patients: San Francisco General Hospital's Approach, California Medical Association

Other pamphlets in Spanish and English can be ordered. If you want pamphlets for your patients on any aspect of AIDS or are looking for professional information not listed above please request it. Contact us at 1-800-522-0399 or in Detroit at 313-567-0399.

AMA Report Reviews 1987 Recommendations on AIDS

At the 1988 AMA Annual Meeting, a report from the Board of Trustees, *Progress on the Prevention and Control of AIDS*, was presented. The report reviews the current status of the seventeen recommendations adopted in 1987 and includes updated information on the progress of efforts to prevent and control AIDS. Below is an abbreviated version of each original (1987) recommendation with the 1988 recommendation listed after. For a complete copy of the report, contact Lisa Strother, coordinator for the MSMS AIDS Education Project.

Recommendation 1

"A commission...should be formed with representatives from the Executive Branch of the Federal Government, the Congress, and the private sector and directed to develop a consensus position for consideration by the aforementioned groups." The Presidential Commission on the Human Immunodeficiency Virus Epidemic was established to advise the president on all aspects of the HIV epidemic.

1988 Recommendation:

The Board recommends that another commission be established to complete the work of the President's AIDS Commission and to provide the essential coordination between public and private institutions that are addressing AIDS.

Recommendation 2

"The communications industry must develop voluntary guidelines for 'PSAs' (Public Service Announcements) regarding AIDS in consultation with the health care community and government officials."

1988 Recommendation:

Overall, the communications industry has performed well in developing PSAs. The AMA will continue to work with the communications industry to educate the public concerning the AIDS epidemic.

Recommendation 3

Called for meetings to be held between the AMA, other physician organizations, and public health officials to deal with the problem of education, counseling, and updating scientific information.

1988 Recommendation:

AMA continue educational efforts as outlined in the AMA's AIDS Action Plan.

Recommendation 4

HIV tests should be readily available to all who wish to be tested and that the tests should be routinely subsidized for all individuals who cannot afford to pay the costs.

1988 Recommendation:

No change in present policy.

Recommendation 5

Established that testing for HIV "...should be mandatory for donors of blood and blood fractions, of organs and other tissues

intended for transplantation in the U.S. or abroad, of semen or ova collected for artificial insemination or in vitro fertilization, for immigrants to the United States, for inmates in federal and state prisons, and for military personnel."

1988 Recommendation:

The Board recommends that:

1. The AMA continues to support the mandatory testing of prison inmates.
2. AIDS education be mandatory in state and federal prisons for both inmates and staff and regularly be presented and updated.

Linked to this recommendation is the issue of mandatory premarital testing. There appears to be no basis for recommending that mandatory premarital testing for HIV be implemented on a wide scale basis, thus, the AMA's voluntary premarital testing policy remains unchanged.

Recommendation 6

Voluntary testing should be regularly provided for patients at sexually transmitted disease and drug abuse clinics, certain individuals seeking family planning services, pregnant women in high-risk areas, and patients from high prevalence areas or who engage in high-risk behavior requiring surgical or other invasive procedures.

1988 Recommendation:

No change from present policy.

Recommendation 7-11

Addressed voluntary testing of high-risk individuals, the anonymous reporting of seropositive persons to public health officials for epidemiologic purposes, pre- and post-test counseling of patients by physicians, and patient consent before voluntary HIV testing.

1988 Recommendation:

No change in the applicable AMA policies is indicated at the present time.

Recommendation 12

Concerned with the adequacy of the public funding for AIDS.

1988 Recommendation:

Continued support for adequate funding for all aspects of this epidemic including education, research and patient care. (Note: in April of this year, the Senate authorized a 1.8 billion dollar budget for education, research, and treatment of AIDS in FY89.)



Recommendation 13

"Antidiscrimination laws must be clarified or amended to cover those who test positive for the antibodies to the AIDS virus," and *Recommendation 14* asked that model confidentiality laws be drafted that can be adopted at all levels of government.

1988 Recommendation:

The AMA recommends vigorous enforcement of existing anti-discrimination statutes as well as the adoption of the AMA's model bill.

Recommendation 15

Requested that a national study be undertaken to determine the prevalence of HIV in the U.S. population and to repeat the study at appropriate intervals in order to gauge its spread.

1988 Recommendation:

In order to determine the rate of spread of the AIDS epidemic, a second national seroprevalence study must be performed. Depending on the outcome of such a second study, additional studies may be indicated.

Recommendation 16

Asked that specific statutes be drafted that not only protect confidentiality of patient information, but also provide for the warning of unsuspecting sexual partners, the protection of physicians for failure to warn, the establishment of clear standards for when physicians should inform public health authorities, and guidelines for the latter who need to do contact tracing.

Recommendation 17

Stated that serious consideration should be given to sanctions in circumstances where an unsuspecting sexual partner subse-

quently discovers a partner's infection and brings a complaint to the attention of authorities.

1988 Recommendation:

The Board recommends that states that do not already have a contact tracing program give serious consideration to implementing such a program. Provisions must be made for adequate safeguards to protect confidentiality of seropositive persons and their contacts, and for the counseling of parties involved.

Breast Milk Transmission of HIV

Concern has been raised about the possibility of transmission of HIV to infants through breast feeding.

1988 Recommendation:

The board recommends that in the U.S. where safe, alternative nutrition is widely available, HIV seropositive women should not breast feed. HIV testing of all human milk bank donors should be mandatory and milk from such donors not be used for human consumption.

Summary:

The report concludes by reiterating the need for more clinical research and research on the connection between AIDS education and what influence it has on behavioral change.

The health education curriculum for K-7 students developed by the National Center for Health Studies is used by 1,500 school districts and could be expanded to include educational material about the risk of HIV infection.

On a final note, the pressing need to deal with the problem posed by IVDA's is stated, and mention of much public misinformation remains regarding AIDS, despite public education campaigns.

Pending AIDS Legislation in Michigan

Several pieces of AIDS legislation in Michigan currently under consideration could have an impact on what is required of physicians and local health departments in terms of reporting of HIV infection and testing requirements. Here is a listing of legislation that is likely to be acted upon.

House Bill 4103

Requires reporting of all incidences of AIDS and requires MDPH to consult with persons diagnosed as having AIDS or who test positive for AIDS.

Sponsor: Rep. Thomas Power, R-Traverse City

House Bill 4880

Permits physicians to contact spouses or other sexual partners of individuals who test positive for the AIDS virus, and provides for physician immunity from liability for breach of confidentiality.

Sponsor: Rep. Richard Bandstra, R-Grand Rapids

House Bill 4980

Requires physicians and health facilities which provide artificial insemination, blood transfusion, or organ transplantation services to test for AIDS.

Sponsor: Rep. Shirley Johnson, R-Royal Oak

House Bill 5026

Provides mechanism for dealing with recalcitrant AIDS patients.

Sponsor: Rep. Michael Bennane, D-Detroit

House Bill 5188

Requires proper training on the subject of AIDS for school nurses and health instructors of elementary and secondary students.

Sponsor: Rep. Teola Hunter, D-Detroit

House Bill 5189

Requires written informed consent from an individual prior to AIDS testing and requires and provides for confidentiality of test results.

Sponsor: Teola Hunter, D-Detroit

Any questions regarding these AIDS-related Bills may be directed to Mary Anne Ford, Chief of State Government Affairs at MSMS.

MSMS will continue to provide progress reports on AIDS legislation in *Medigram* and *Michigan Medicine*.

AIDS in the Workplace Policy Guidelines Endorsed by MSMS Board of Directors:

Employers throughout Michigan are seeking guidance from their corporate physicians and from state and local health organizations in dealing with complex policy questions regarding AIDS. Questions regarding AIDS screening, the ability of persons with AIDS to work, health benefits, and hazards to other employees are being asked frequently. To respond to these concerns, the Liaison Committees with Corporate Medical Directors of both MSMS and the Wayne County Medical Society formed a Joint Ad Hoc Committee on AIDS in the Workplace.

The development of policy guidelines is the first step in the Ad Hoc Committee's efforts to offer guidance to employers regarding AIDS. Based on a model developed by the American Occupational Medical Association, the guidelines will provide a model for Michigan employers developing AIDS policies. Implementation of the policy guidelines will, of course, require the expertise of several individuals within any organization utilizing them, including the medical directors.

The policy guidelines address the issues of AIDS screening, employee education, continuing employment of persons with AIDS and those infected with the AIDS virus, confidentiality of medical information, and concerns of co-workers. The following guidelines have been endorsed by MSMS:

1. Because AIDS is not transmissible by the usual social

contact acceptable in the workplace, there is no reason to consider AIDS as different from any other health problem with regard to employment.

2. AIDS should be dealt with as any other medical condition with respect to employment and benefit provisions.
3. Employees with AIDS should be permitted to work as long as they are physically able to perform their job duties and should be allowed and encouraged to remain as productive employees.
4. Screening tests for AIDS are not considered to be practical nor particularly helpful with regards to the workplace setting and therefore employers should not require HIV screening as part of general pre-employment or workplace physical examinations.
5. Every effort should be made to establish and conduct educational programs about AIDS directed toward managerial and non-managerial employees alike.
6. Employee concerns about working with an AIDS patient should be directed to a member of the management team. Efforts should be made to address these concerns without negatively affecting the patient, other co-workers, or the overall workplace environment.
7. As is true with any personally identifiable medical information, all medical information regarding an employee with AIDS or suspected of having AIDS should be kept strictly confidential.

Michigan Department of Public Health Acquired Immune Deficiency Syndrome (AIDS) Statistics

AUGUST 8, 1988

YEAR DIAGNOSED	TOTAL CASES		TOTAL DEATHS	TRANSMISSION MODE		TOTAL CASES		AUG. '87 TO JUL. '88*	
1981	2		2	Male Homo/Bisex		444	58%	160	51%
1982	2		1	IV Drug Abuser		171	22%	92	29%
1983	18		16	Male Homo/ IVDA		46	6%	13	4%
1984	43		40	Hemophiliac		26	3%	9	3%
1985	88		79	Heterosexual Cases		25	3%	13	4%
1986	188		123	Transfusion		13	2%	3	1%
1987	273		127	Pediatric**		12	2%	6	2%
1988	153		43	Undetermined***		30	4%	16	5%
TOTAL	767		435	TOTAL		767	100%	312	100%

SEX	TOTAL CASES		AUG. '87 TO JUL. '88*		AGE	TOTAL CASES		AUG. '87 TO JUL. '88*	
Male	701	91%	277	89%	0-12	12	2%	6	2%
Female	66	9%	35	11%	13-19	6	1%	2	1%
					20-29	169	22%	63	20%
					30-39	331	43%	135	43%
					40-49	159	21%	68	22%
					50+	90	12%	38	12%

RACE	TOTAL CASES		AUG. '87 TO JUL. '88*	
White	399	52%	148	47%
Black	346	45%	152	49%
Hispanic	20	3%	12	4%
Other	2	0%	0	0%



Michigan Cases by County

COUNTY	CASES	COUNTY	CASES	COUNTY	CASES
Baraga	2 0%	Hillsdale	1 0%	Muskegon	9 1%
Barry	1 0%	Ingham	26 3%	Newaygo	2 0%
Bay	1 0%	Ionia	4 1%	Oakland	93 12%
Benzie	1 0%	Jackson	13 2%	Oceana	2 0%
Berrien	7 1%	Kalamazoo	14 2%	Ottawa	6 1%
Branch	5 0%	Kent	26 4%	Roscommon	1 0%
Calhoun	12 2%	Lapeer	1 0%	Saginaw	7 1%
Cass	1 0%	Leelanau	2 0%	St. Clair	3 0%
Clinton	1 0%	Lenawee	2 0%	St. Joseph	3 0%
Eaton	1 0%	Livingston	2 0%	Shiawassee	1 0%
Genesee	28 3%	Macomb	25 4%	Van Buren	1 0%
Gr. Trav	3 0%	Marquette	5 1%	Washtenaw	31 4%
Gratiot	2 0%	Menominee	2 0%	Wayne	80 10%
		Monroe	5 1%	DETROIT	335 43%

* Figures include 312 cases diagnosed August 1, 1987 thru July 31, 1988. Reporting for this time period is incomplete.

** Epidemiologic data suggests transmission from infected mother to child before, at, or shortly after birth, Hemophilia/Coagulation disorder, or transfusion of blood or blood products.

*** This category includes patients on whom risk information is incomplete (due to death, refusal to be interviewed, or loss to follow-up), patients who are still under investigation, and interviewed patients on whom no risk was identified

Michigan Counseling and Testing Sites

With the exception of the U of M Health Center, all sites perform testing by appointment only.

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Benton Harbor
616/926-7121

Branch-Hillsdale-St. Joseph
809 Marshall Road
Coldwater
517/279-9561

Calhoun County
190 E. Michigan Ave.
Battle Creek
616/966-1210

C-HAG
(Community Health Awareness Group)
Detroit
313/872-2424

Chippewa County
140 W. Spruce St.
Sault Ste. Marie
906/635-1566

Clinton County
306 Elm St.
St. Johns
517/224-7772

Detroit City
Herman Kiefer Health Complex
313/876-0980

Genesee County
310 W. Oakley
Flint
313/257-3597

Grand Traverse-Leelanau-Benzie Traverse City
616/922-4831

Gratiot County
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Jackson
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Kalamazoo County
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Kalamazoo
616/383-8920, or 383-8856
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616/383-8888

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Grand Rapids
616/774-3014, reg. hours MTWF
Thursday from 2 - 4 p.m.

Macomb County
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Midland County
517/832-6665

Monroe County
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Monroe
313/243-7174

Montcalm County
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Stanton
517/831-5237

Muskegon County
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Muskegon
616/724-6415

Oakland County - North
1200 N. Telegraph
Pontiac
313/858-3681

Oakland County - South
27725 Greenfield
Southfield
313/424-7155

Ottawa County - Grand Haven
950 Taylor
Grand Haven
616/846-8360

Ottawa County - Holland
323 N. River
Holland
616/396-5266

Ottawa County - Hudsonville
3811 Port Sheldon Rd.
Hudsonville
616/669-0040

Saginaw County
1600 N. Michigan Ave.
Saginaw
517/771-0877

St. Clair County
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Port Huron
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LETTERS/Continued

should probably be inviting State Legislators and Senators into the operating rooms to witness firsthand, the problems and dilemmas that physicians must face. Short of taking some of these tactics for public education, we are accused of malpractice when things "don't work out." I believe that all the professions suffer under a "cloak of secrecy" and, quite frankly, I have experienced this in dealing with the legal rep-

resentation I have had through MPMLC.

I would urge that we all — physicians, lawyers, and insurance carriers — open the door to public scrutiny and what actually goes on. It seems to me that this is a time for innovative and imaginative approaches.

Oliver D. Grin Jr, MD,
Grand Rapids

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Breast cancer prevention update slated for October

By Dean Sienko, MD

The Michigan Division of the American Cancer Society will sponsor a breast cancer prevention update Oct. 28, 1988, at the Radisson Hotel, Lansing.

As a member of the Michigan Division's Professional Education Committee, I strongly encourage all primary care physicians to attend this meeting for a variety of reasons.

The most common cancer site for Michigan women is the breast. In 1985, 4,848 cases of breast cancer were diagnosed among Michigan women; this represents 30.7 percent of all female cancer cases diagnosed that year. These statistics estab-

The author is a medical epidemiologist, MDPH, and a member, Professional Education Committee, American Cancer Society.

lish that breast cancer prevention should be a priority for all physicians. The structure of our health care delivery system designates the primary care physician for the bulk of such preventive practice.

"The most common cancer site for Michigan women is the breast."

While we do not understand how to prevent the onset of breast cancer (i.e. primary prevention), there is a strategy we can follow to limit morbidity and prevent mortality from breast cancer

once it has occurred (i.e. secondary prevention). This strategy centers on a three-pronged effort: breast self-examination, clinical breast examination, and mammography. Primary care physicians can play a pivotal role in assuring that this strategy is pursued to its maximum benefit.

First, primary care physicians should ensure that their patients understand the importance of, and can demonstrate proper technique in, the performance of breast self-examination. Second, these physicians should be skilled at conducting a thorough breast physical examination. And third, they should be aware of the benefits of screening mammography, and recommend this procedure to their patients at appropriate intervals.

Although it appears that more and more physicians are practicing breast cancer prevention, the following examples suggest that there is room for improvement. One study showed that only slightly more than half (53-69 percent) of all women surveyed reported performing monthly breast self-examination. Another study revealed that among women 40-49 years old who had seen a physician in the previous year, 30 percent had not had a breast physical examination. Additionally, a 1984 American Cancer Society (ACS) survey noted that only 11 percent of physicians followed the ACS guidelines for screening mammography.

The primary care setting offers an opportunity to constructively influence the patient's decision to

adopt preventive practices; this is particularly true in breast cancer prevention. Patients can be instructed on breast self-examination while the physician provides a physical examination. Furthermore, studies have demonstrated that women who have mammograms frequently do so because their physicians advised them to have the test; while, women who have not had a mammogram report that their physicians never recommended it.

Improved adherence to prevention guidelines should have a significant impact on reducing morbidity and mortality from breast cancer. It will also help to protect physicians from lawsuits charging them with failure to diagnose breast cancer. And so, the purpose of the breast cancer prevention program slated for October is to address these issues and assist primary care physicians with preventive breast care.

For further information, or to register for the breast cancer prevention update, call the Michigan Division of the ACS at (517) 371-2920, or your local ACS chapter.

(References for this article are available from *Michigan Medicine* upon request.)

Participants needed for research study

James R. Sowers, MD, chief of endocrinology and metabolism at Harper-Grace Hospitals, along with a team of researchers, is looking for participants for a re-

search study involving the use of a drug which may reduce cholesterol build-up in the arteries.

Specifically, the researchers are looking for participants who have high blood pressure, plaque buildup in the arteries and a relatively normal blood cholesterol count. In return, those who qualify will receive free health treatment, including medication, for the next three years.

The study involves the use of Isradipine, a drug that may be able to decrease plaque buildup and eliminate surgery to correct too-narrow arteries.

Interested individuals can call Paula Zemel, PhD, or Jackie Greene, study coordinator at Harper Hospital, (313) 745-4008.

Social relationships affect life span, U-M study shows

Scientists have known for some time that isolated, lonely adults are less healthy and more likely to die prematurely, but they found it hard to prove which was the cause and which was the effect.

Now a University of Michigan report that summarizes the experimental and survey data collected over the past two decades affirms that a lack of social relationships has a negative impact on health.

"The data indicates that social isolation is as significant to mortality rates as smoking, high blood pressure, high cholesterol, obesity and lack of physical exer-

cise," say James S. House, research scientist at the U-M Institute for Social Research (ISR); Karl R. Landis, research assistant at ISR; and Debra J. Umberson, ISR research fellow. "In fact, when age is adjusted for, social isolation is as great or greater a mortality risk than smoking."

Their report appeared in the July 29 issue of *Science*. "The scope and magnitude of the evidence is similar to the data on smoking that was available at the time of the first surgeon general's report issued in 1964," they add.

Today's adult is less likely to live with others, to be married, to belong to voluntary organizations and to visit informally with friends. "It is ironic," the U-M researchers say, "that, just as we are beginning to understand the importance of social relationships for health, their prevalence and availability may be declining."

WSU reaches \$15 million goal

The Wayne State University School of Medicine has announced the successful completion of its capital campaign to raise funds for the construction of the Louis M. Elliman Clinical Research Building. The campaign goal of \$15 million has been met through donations from charitable foundations, corporations and individuals, according to Robert J. Sokol, MD, WSU interim dean of medicine.

Continued on page 570

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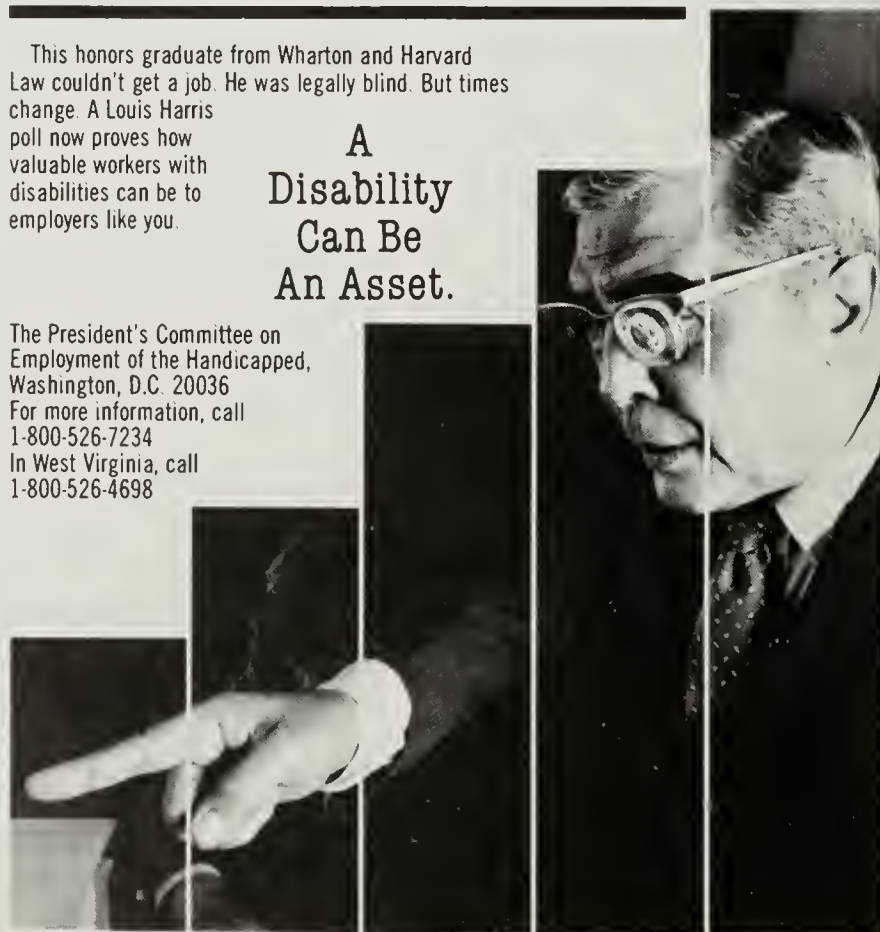
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- In spite of its unique quality level, charges at Hutzel are generally slightly less than at local hospital clinics.
- The Hutzel Fertility Center's modern facilities are located on the Hutzel Hospital Campus at The Detroit Medical Center, and recently have been expanded by more than 40 percent to accommodate growing demand.

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For more information about any of Hutzel's fertility programs, please call 745-0499 or 577-1066.



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NEWSFRONTS/Continued

The capital campaign was launched early in 1987 after a \$1.5 million gift to WSU from philanthropist Louis Elliman initiated plans for the addition of a 100,000-square-foot research facility within the Detroit Medical Center. The three-story Elliman building, named in honor of the primary benefactor, is now being constructed at the corner of Canfield and Brush and is expected to be completed late this year.

The Elliman Clinical Research Building will provide 63,000 square-feet of space for 48 medical research laboratories. In addition to providing the expanded space, the building will allow for the consolidation of several medical departments and facilitate interdisciplinary exchanges.

This modern facility will increase the School's ability to attract outstanding scientists and obtain additional research funding," Doctor Sokol said.

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CDC definitions for nosocomial infections

CDC Definitions for *Nosocomial Infections*, 1988, is a new set of definitions developed by the CDC for surveillance of nosocomial infections. The definitions combine specific clinical findings with results of laboratory and other tests that include recent ad-

Continued on page 573

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NEWSFRONTS/Continued

vances in diagnostic technology. The definitions are formulated as algorithms. For certain infections in which the clinical or laboratory manifestations are different in neonates and infants than in older persons, specific criteria are included. The definitions include criteria for common nosocomial infections as well as infections that occur infrequently but have serious consequences.

To order, request PB88-187117/KJV, *CDC Definitions*

for *Nosocomial Infections, 1988*, 14 pp., \$9.50, plus \$3 handling charge, from NTIS, Springfield, VA 22161, (730) 487-4650.

**MSMS-sponsored
Foundation awards
\$8,500 in grants**

The Health Education Foundation sponsored by the Michigan State Medical Society recently announced the recipients of two grants totaling \$8,500, one for

the study of fats in the blood and the other for health promotion.

A \$5,500 grant will go to the Department of Family Practice at Michigan State University's College of Human Medicine to study ways to reduce lipids (fats) in the blood of primary care patients.

A \$3,000 grant will go to the Michigan Health Council to continue its involvement in health screening fairs and worksite wellness programs. □

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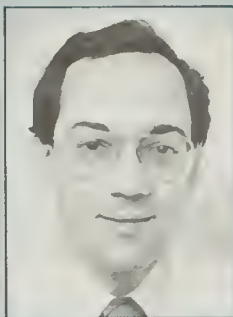
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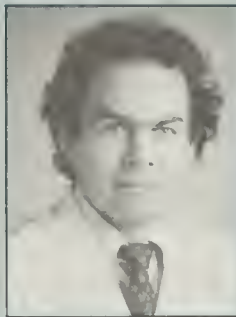
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PHYSICIANS IN THE NEWS



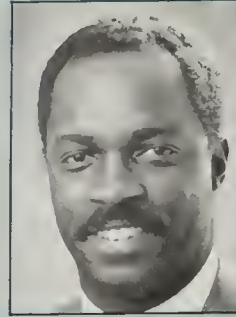
Zervos



Kelly



Keshishian



Nichols

William Beaumont Hospital, Royal Oak, recently announced the following staff appointments: **Marcus Zervos, MD**, Birmingham, is the new director of the hospital's Infectious Diseases Research Laboratory and is a member of the Adult Infectious Disease division. **Arlene Bradley Levine, MD**, also of Birmingham, was appointed director of Interventional Cardiology effective June 1, 1988. **Lewis H. Rosenbaum, MD**, West Bloomfield, and **Todd S. Wilkinson, MD**, Bloomfield Hills, recently assumed new responsibilities at the hospital. Doctor Rosenbaum is vice chief of medical services and associate program director for the Internal Medicine Teaching Services. Doctor Wilkinson is chief of General Internal Medicine, a division of the Department of Medical Services.... Hoffmann La Roche Inc. has awarded a research grant to **Carl B. Lauter, MD**, West Bloomfield, chief of Medical Services,

William Beaumont Hospital. Doctor Lauter was selected to receive the grant at Research Rounds, Roche's annual infectious disease conference, held earlier this year in Scottsdale, Arizona.... **Charles C. Vincent, MD**, Detroit, was elected the 1988-89 president of the Wayne County Medical Society (WCMS) at its 138th Annual Business Meeting in June. Doctor Vincent succeeds **Gilbert B. Bluhm, MD**, West Bloomfield. Doctor Vincent is affiliated with Hutzel, Harper-Grace, Southwest Detroit and Detroit Receiving Hospitals. He is Chief of Gynecology at Detroit Receiving. He is a board certified obstetrician gynecologist and surgeon and graduated from Wayne State University School of Medicine in 1958 where he was elected Alpha Omega Alpha. Doctor Vincent is past president of the Detroit Medical Society, and was voted "Physician of the Year" by that organization in 1972 and 1983.... **Michael**

Kelly, MD, MPH, Lansing, is the new medical director of St. Lawrence Hospital's "On the Job" Occupational Health Service. Doctor Kelly is certified by the American Board of Preventative Medicine in Occupational Medicine. There are only about 700 physicians with this certification in the United States.... **Marc Keshishian, MD**, Farmington Hills, has been promoted to the new position of associate medical director of Comprehensive Health Services in Detroit. He previously was chief of staff in charge of Comprehensive's Northwest Medical Center.... **Ronald A. Nichols, MD, MPH**, Lansing, has been appointed Medical Director of the Perinatal Center at Sparrow Hospital in Lansing. As the director of Perinatology at Sparrow, Doctor Nichols will be assisting obstetricians throughout the mid-Michigan area as they provide care to pregnant women with serious medical problems. □

Michigan State Medical Society

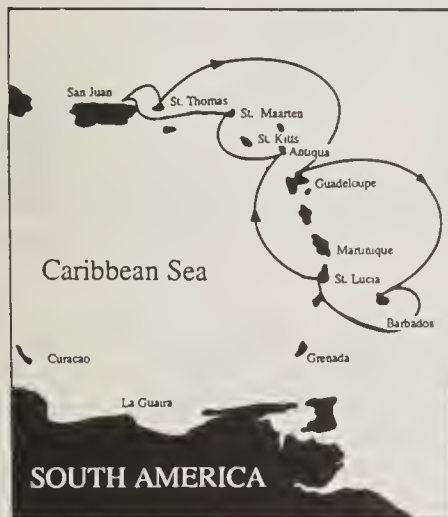
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12 Noon Luncheon



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For more information, call Amy Fistler at MSMS Headquarters (517) 337-1351.

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Please enclose your check payable to Michigan State Medical Society and send to Amy Fistler, Physician Service Group, Inc.; P.O. Box 950; 120 W. Saginaw; East Lansing, MI 48826-0950. Telephone: (517) 337-1351. Confirmation of your registration along with directional map to Hyatt Regency Dearborn Hotel will be sent to you.

CORRECTION

Richard A. Stone, MD, Mt. Clemens (second from left) was incorrectly identified in the August issue of *Michigan Medicine*. The correct photo caption follows.

The planning committee met recently to complete the program for the October 6, MSMS medical practice management conference. The conference is sponsored by the MSMS Young Physicians Section, and will be held at the Hyatt Regency Dearborn. From left around the table are Mitchell Rinek, MD, Lansing; Richard A. Stone, MD, Mt. Clemens, chairman, MSMS Young Physicians Section; Thomas J. Archambeau, MD, Lansing; Jack A. Dekkinga, MD, Jenison; and Tama D. Martini, MD, Ann Arbor.



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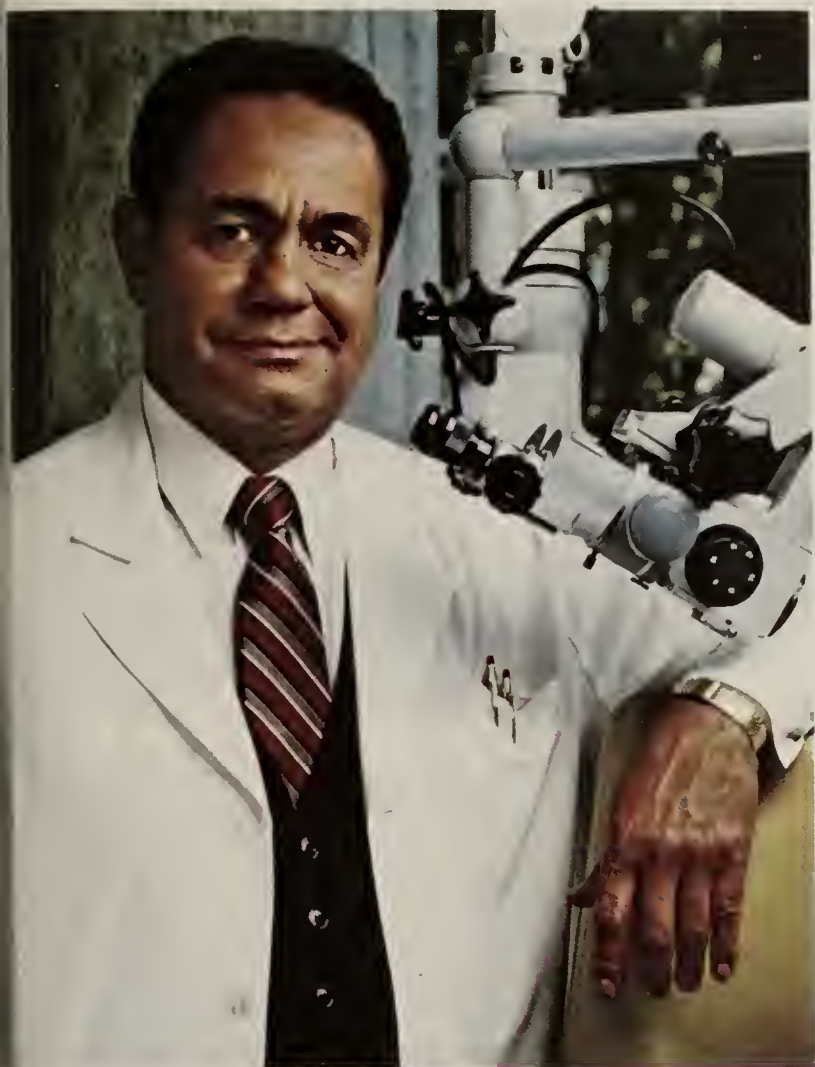
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DALE L. TIPTON, M.D.

Associate Clinical Professor, Department of Otolaryngology, Head and Neck Surgery, University of California School of Medicine, San Francisco, California.
Chairman, Division of Otolaryngology, Franklin Hospital, San Francisco, California.
Lieutenant Colonel, U.S. Army Reserve.

EDUCATION University of California at Berkeley, A.B. Physiology; University of California School of Medicine, San Francisco, M.D. and Master of Science, Pharmacology.

RESIDENCY University of California School of Medicine, San Francisco: General Surgery — 2 years; Otolaryngology — 3 years.

FELLOWSHIPS National Institute of Health Fellow; Cancer Research Institute, University of California, San Francisco.

OUTSTANDING ACHIEVEMENTS Freshman Medical Student Research Award; Class President — 2nd year medical school; Student Body President — senior year medical school; Special Award by National Institute of Health to attend and present paper at International Congress of Otolaryngology in Tokyo, Japan; Chairman, Department of Otolaryngology, San Francisco General Hospital 1970-76; Chief of Medical Staff, Franklin Hospital 1982-84.



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Precautions: General—1 Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2 Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3 Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2 -receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

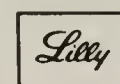
Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

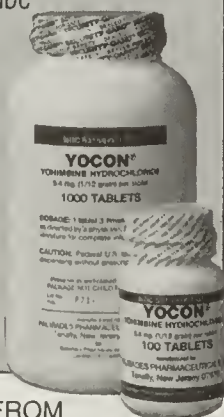
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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October 6

Hyatt Regency, Dearborn

Medicare Update

October 12

Beaumont Hospital, Royal Oak

Medicare Update

October 13

Kellogg Center, East Lansing

Personnel Management/Marketing Your Medical Practice

October 20

Hilton Inn, Novi

Fostering Better Patient/Physician Relations

October 26

Kellogg Center, East Lansing

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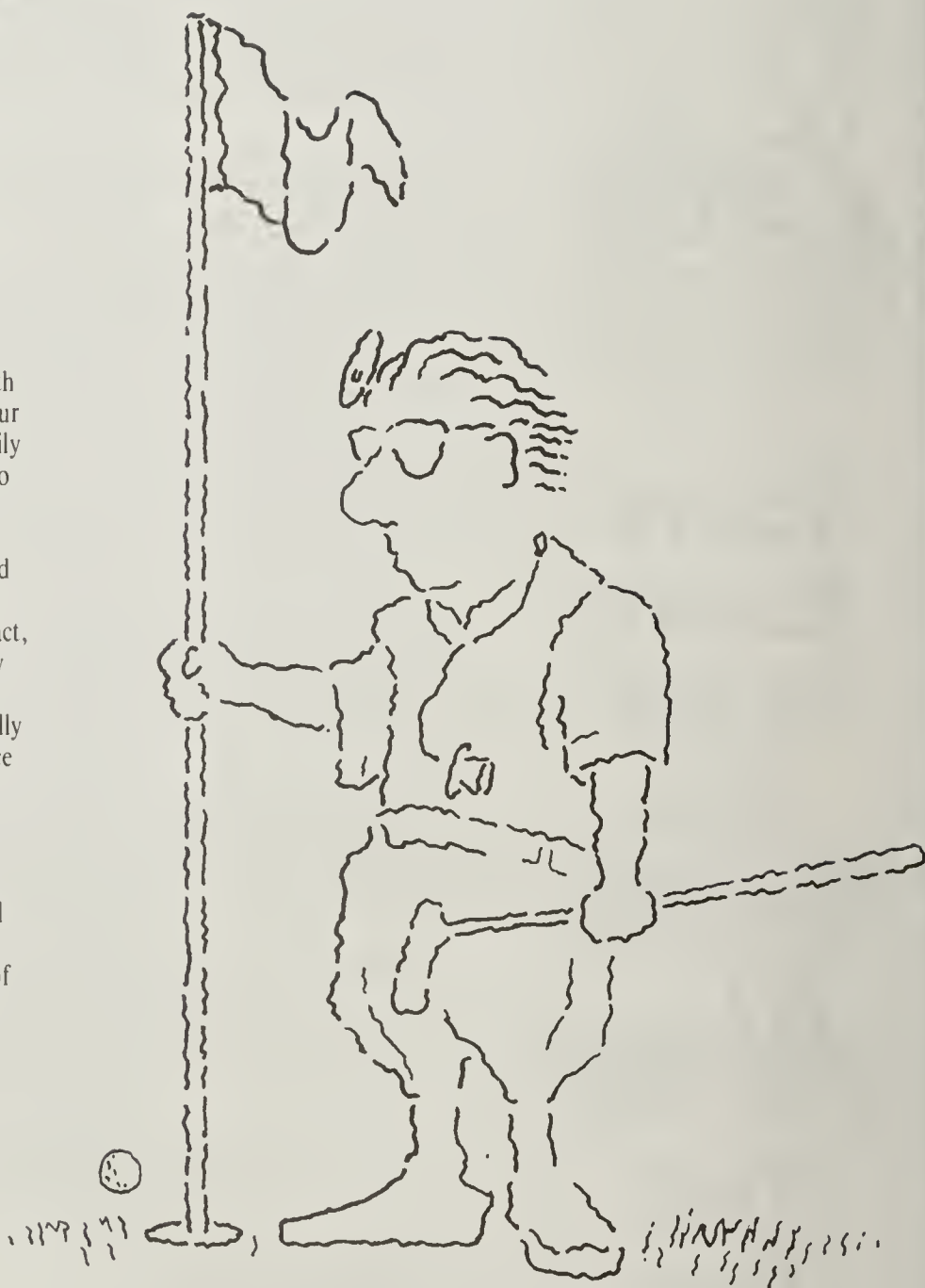
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

September

15, Effects of Cardiovascular Disease in the Older Patient. Location: Southfield Hilton, Southfield. Sponsor: Henry Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 3 hours Category I Credit.

15-16, Neonatal Emergencies. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Pediatrics and Communicable Diseases, Section of Newborn Services and Pediatric Pulmonary Medicine. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 14 hours Category I Credit.

15-17, 11th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 13 hours Category I Credit.

17, Cardiovascular Management: Current Trends and New Directions. Location: Thomas Edison Inn, Port Huron. Sponsor: American Heart Association of Michigan and Mercy Hospital. Contact: Lori Hall, Program Consultant, American Heart Association of Michigan and Mercy Hospital, 16310 W. 12 Mile Road, P.O. Box 160, Lathrup Village 48076 (313) 557-9500. Approved for: 5 hours Category I Credit.

17, Cytopathology of Breast Lesions. Location: Henry Ford Hospital. Sponsor: Henry

Ford Hospital. Contact: Henry Ford Hospital, Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 5.5 hours Category I Credit.

19-20, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 14 hours Category I Credit.

22-24, 19th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan State University College of Human Medicine, The International Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. Contact: Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616) 774-0440. Approved for: 18 hours Category I Credit.

22-25, American College of Physicians Michigan Chapter in Association with Michigan Society of Internal Medicine 34th Annual Michigan Scientific Meeting. Location: Grand Traverse Resort, Grand Traverse Village. Sponsor: American College of Physicians Michigan Chapter and Michigan Society of Internal Medicine. Contact: ACP-Michigan Chapter, B-208 Clinical Center, East Lansing 48824. Approved for: 18.5 hours Category I Credit.

26-27, Sexual Exploitation of Persons with Disabilities. Location: Michigan League, 911

North University, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Physical Medicine and Rehabilitation, Kenny Rehabilitation Foundation of Michigan. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 14 hours Category I Credit.

29, Malpractice Risk Prevention for the Medical Office. Location: Bronson Center for Health Education. Sponsor: Bronson Healthcare Group and Southwestern Michigan Area Health Education Center. Contact: Kris Smoker, Bronson Healthcare Group, One Healthcare Plaza, Kalamazoo 49007 (616) 341-8869. Approved for: 6 hours Category I Credit.

30, Management of Behavior Problems in Older Adults. Location: Sheraton Inn, Kalamazoo. Sponsor: Older Adult Program of Delano Clinic, Borgess Geriatric Center and Southwestern Michigan Area Health Education Center. Contact: Continuing Medical Education Department, Southwestern Michigan Area Health Education Center, (616) 341-6360. Approved for: 6 hours Category I Credit.

October

1, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500. Approved for: 5 hours Category I Credit.

1, Ultrasound '88. Location: Bronson Center for Health Education, Kalamazoo. Sponsor: Bronson Ultrasound Department and Southwestern Michigan Area Health Education Center. Contact: Bronson Ultrasound Department, (616) 341-8380. Approved for: 6.5 hours Category I Credit.

1, AIDS and Primary Care Physicians in Michigan. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann

Continued on next page

CATEGORY I/Continued

Arbor 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category 1 Credit.

1-2, Advanced Cardiac Life Support Provider Course. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 16 hours Category 1 Credit.

2, Michigan Chapter American Academy of Pediatrics Annual Scientific Meeting. **Location:** Grand Traverse Resort and Conference Center, Traverse City. **Sponsor:** Michigan Chapter American Academy of Pediatrics. **Contact:** Miles Tiernan, 32245 Hearthstone, Farmington Hills, MI 48018 (313) 553-3646. **Approved for:** 7 hours Category I Credit.

3-4, Medical and Legal Perspectives on Impairment Evaluation and Disability Considerations of the Musculoskeletal System. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Surgery and Department of Physical Medicine and Rehabilitation. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category 1 Credit.

3-4, Ear, Nose and Throat Practicum. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 17 hours Category 1 Credit.

4, Critical Clinical Issues in the Care of the Elderly. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category 1 Credit.

November

30, Diabetes Mellitus: Sexuality, Pregnancy and Aging. **Location:** Fairlane Manor, Dearborn. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313) 876-3072. **Approved for:** 7.5 hours Category I Credit.

December

4-5, The Difficult Airway. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category 1 Credit.

9, Basic Life Support for Health Professionals. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 5 hours Category 1 Credit.

10, Advanced Cardiac Life Support Recertification Course. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category I Credit.

January

13, Basic Life Support for Health Professionals. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 5 hours Category 1 Credit.

14-15, Advanced Cardiac Life Support Provider Course. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:**

University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 16 hours Category 1 Credit.

29-2/3, The Thirteenth Annual Midwinter Family Practice Update. **Location:** Boyne Highlands Inn, Harbour Springs. **Sponsor:** University of Michigan Medical School, Department of Family Practice with the Michigan Academy of Family Physicians, and Department of Postgraduate Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

February

10, Basic Life Support for Health Professionals. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 5 hours Category 1 Credit.

11, Advanced Cardiac Life Support Recertification Course. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category 1 Credit.

10-12, Advanced Cardiac Life Support Instructor Course. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 21 hours Category 1 Credit.

MEETINGS

MSMS MEETINGS

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

October

6, Financial and Medical Practice Management Conference, sponsored by MSMS Task Force on Young Physicians, Hyatt Regency Hotel, Dearborn, contact: Linda Munson (517) 337-1351.

15, Primary Care Medicine Seminar, Hidden Valley, M-32 East, Gaylord, in cooperation with MSMS AIDS Speaker's Bureau, contact: Dr. Matias, 429 N. Center, Gaylord 49735, (517) 732-3514 or Lisa Strother, P.O. Box 950, East Lansing 48826-0950, (517) 337-1351.

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517)337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

September

22-24, Technology and Ethics: Genetic Screening, Gene Therapy and Reproduction — Developments and Implications, Westin Hotel Tabor Center, Denver, Colorado, American Medical Association and the Hastings Center, contact: American Medical Association, Department of Registration Services, 535 North Dearborn St., Chicago, IL 60610, 1-800-621-8335.

24, Health Hazards of Radon, Academy of Medicine of Cincinnati, sponsored by American Medical Association, the U.S. Environmental Protection Agency and the Academy of Medicine of Cincinnati, contact: Vicki Grosso, Science and Technology, American Medical Association, (312)645-4574.

October

5-6, AMA Seventh Annual Science Reporters Conference, Westin St. Francis Hotel, San Francisco, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

26, Research Symposium on Drug Abuse, Chicago Marriott, American Medical Association and the Association for Medical Education and Research in Substance abuse (AMERSA) and National Institute on Drug Abuse (NIDA), contact: American Medical Association, 535 North Dearborn St., Chicago, IL 60610, 1-800-621-8335.

26-30, AMA Ninth National Conference Impaired Health Professionals: Visions and Values, Chicago, contact: AMA, 535 North Dearborn St., Chicago, IL 60610, (312) 645-4344.

27-28, Innovation Imperiled? Medical Technology in an Era of Cost Containment, O'Hare Marriott Hotel, Chicago, American Medical Association and the Health Policy Agenda for the American People, contact: American Medical Association, 535 N. Dearborn St., Chicago, IL 60610, 1-800-621-8335.

December

4-7, AMA Interim Meeting, Dallas, Texas, contact: AMA, 535 North Dearborn St., Chicago, IL 60610, (312) 645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

September

28, Michigan Urological Society

Meeting, Wayne State University, contact: Isaac Powell, MD, 1017 Harper Professional Building, 4160 John R, Detroit 48201 (313) 833-3320.

October

2, Michigan Chapter, American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Resort and Conference Center, Traverse City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018, (313) 553-3646.

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823, (517) 332-6500.

NATIONAL SPECIALTY SOCIETIES MEETINGS

September

14-17, American Group Practice Association Annual Meeting, Hotel Intercontinental, San Diego, CA, contact: American Group Practice Association, 1422 Duke Street, Alexandria, VA 22314, (703) 838-0033.

23-24, American Academy of Facial Plastic and Reconstructive Surgery Annual Meeting, Washington, DC, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005, (202) 842-4500.

26-29, American College of Emergency Physicians Scientific Meeting, New Orleans Convention Center, New Orleans, LA, contact: American College of Emergency Physicians, P.O. Box 619911, Dallas, TX 75261-9911, (214) 550-0911.

Continued on next page

MEETINGS/Continued

October

1-6, American Academy of Family Physicians Annual and Scientific Meetings, New Orleans Marriott, New Orleans, LA, contact: American Academy of Family Physicians, 1740 W 92nd Street, Kansas City, MO 64114, (816) 333-9700.

3-7, American College of Chest Physicians Scientific Meeting, Anaheim Hilton, Anaheim, CA, contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068, (312) 698-2200.

8-12, American Academy of Ophthalmology Annual Scientific Meeting, Las Vegas, NV, contact: American Academy of Ophthalmology, P.O. Box 7424, 655 Beach, San Francisco, CA 94120, (415) 561-8500.

8-12, American Society of Anesthesiologists Annual Meeting, San Francisco Hilton, San Francisco, CA, contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068, (312) 825-5586.

17-19, American College of Gastroenterology Annual Meeting, Hilton, New York, NY, contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944, (617) 927-8330.

23-28, American College of Surgeons Annual Meeting, Hilton, Chicago, IL, contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611, (312) 664-4050.

26-30, American Academy of Child and Adolescent Psychiatry Annual Meeting, Westin Hotel, Seattle, WA, contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.E., Washington, DC 20016, (202) 966-7300.

30-11/4, American Academy of Physical Medicine and Rehabilitation Annual Scientific Meeting, Convention Center, Seattle, WA, contact: American Academy of Physical Medicine and Rehabili-

tation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603 (312) 922-9366.

31-11/5, American Academy of Pediatrics Annual Meeting, San Francisco, CA, contact: American Academy of Pediatrics, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007 (312) 288-5005.

November

2-5, The Wrist 1988, American Society for Surgery of the Hand, Saddlebrook Resort, Tampa, FL, contact: American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014, (303) 755-4588.

12-16, American College of Allergists Annual Scientific Meeting, Westin Century Plaza, Los Angeles, CA, contact: American College of Allergists, 800 E. Northwest Highway, Suite 101, Mt. Prospect, IL 60056, (312) 255-0380.

December

3-8, American Academy of Dermatology Annual Scientific Meeting, Washington, DC, contact: American Academy of Dermatology, 1567 Maple Avenue, P.O. Box 3116, Evanston, IL 60204-3116, (312) 869-3954.

OTHER MEETINGS

September

23, Linking Research and Practice in Nutrition Education, Hannah Ballroom, East Lansing, contact: Dairy Council of Michigan, 1-800-548-8097.

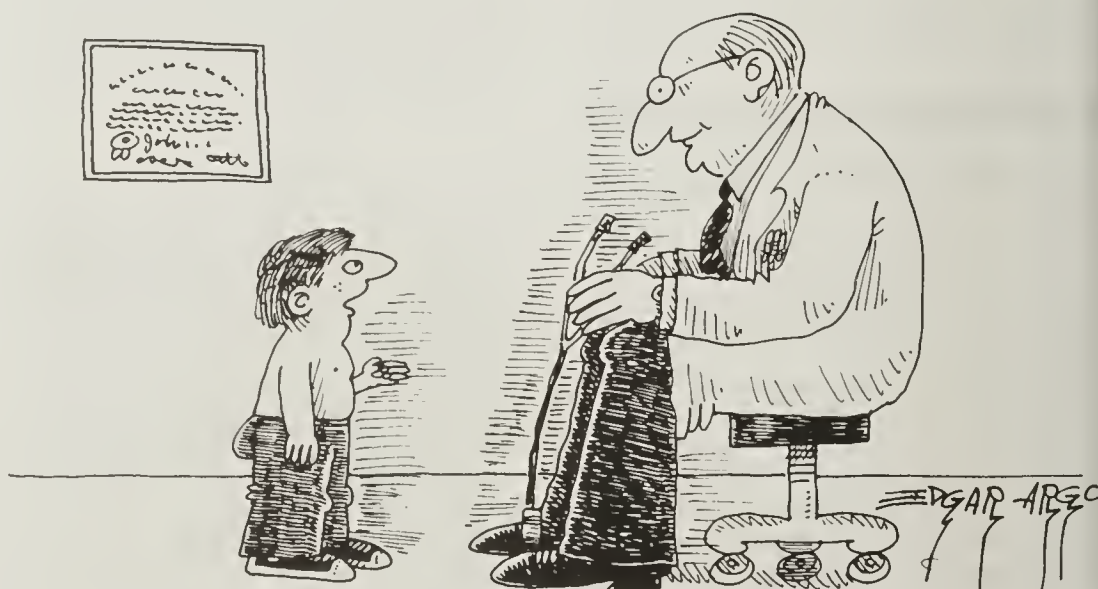
October

14-16, Sepulveda Epilepsy Education Program, Ann Arbor, contact: The Reverend Charles H. Swinehart, Jr., Epilepsy Support Services, 6159 Aldine Drive, Brighton, 48116, (313) 229-4193.

16-19, Mental Health 1990s: Partnerships and Strategies, Cobo Conference/Exhibition Center, Detroit, contact: Michigan Department of Mental Health, P.O. Box 30182, Lansing 48909.

November

3-4, Family Practice Research Day XII: Research in the Residency, The University Club, Michigan State University Campus, East Lansing, contact: Douglas B. McKeag, MD, Chairman, Michigan Family Practice Research Day XII, B-100 Clinical Center, Michigan State University, East Lansing 48824, (517) 353-0772.



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FAMILY PRACTICE, MARSHFIELD CLINIC is seeking BE/BC family practitioner to join its expanding department in Marshfield. The department is currently staffed by five family practitioners with plans to add three additional members. With the exception of obstetrics, which is done by staff obstetricians, the practice offers a full range of inpatient and outpatient services. Full specialty consultation is readily available in-house. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to \$85,000 with salary in 2 years up to \$110,000. Fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect (715) 387-5376.

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PSYCHIATRIST. A progressive 131-bed two-hospital system is seeking a Board certified or Board

Continued on next page

CLASSIFIED/Continued

eligible psychiatrist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

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ENT. A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible otolaryngologist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospital, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

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Central Missouri for physicians with appropriate credentials in; family practice; internal medicine; obstetrics/gynecology; pediatrics; otolaryngology; orthopedic surgery; general surgery; emergency medicine; radiology; psychiatry; geriatrics; and dermatology. Interested individuals please forward curriculum vitae in confidence to: Tim Ignash, Senior Associate, Bernie Hoffman Associates, Inc., 15565 Northland Drive, Suite 800 East, Southfield, MI 48075 (313) 557-9340.

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The teens; trying times

By Fred W. Bryant, MD

The coming of the industrial revolution concentrated population in cities where 75 percent of us now reside, encouraged movement (50 percent of us move every five years) and caused an influx of immigration at the rate of one million per year. In addition, it split asunder the family — bread-winner father gone at dawn and all day long, house-keeper mother attending domestic duties, child-bearing and child-rearing.

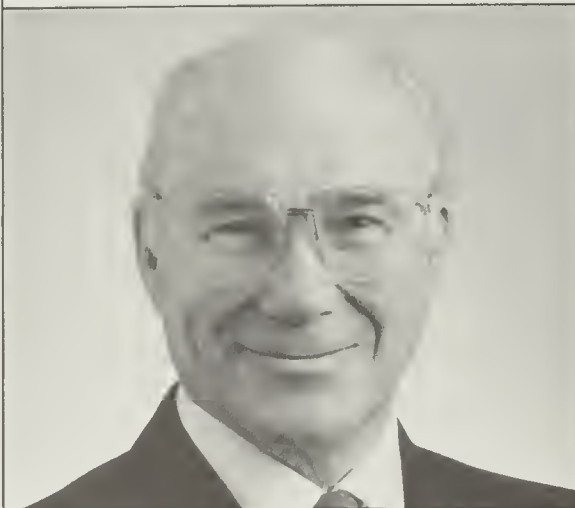
Changing perceptions saw jobs as drudgery (a “rat race”) or threatening (a “jungle”). Attitudes arose to protect the home from the harsh outside world and to prolong the nurturing period. Labor laws were enacted in the 1800s to prevent or limit child labor, to require compulsory education from ages six to 16, and to define legal ages when juveniles were eligible to perform adult tasks. Adolescence became an age apart, enlarged still more in the century that followed.

It is worthwhile to examine changing conditions at work and home, and how adolescence is affected.

Forces at work

In 1900, 31 percent of jobs were in the service industry, now the percentage is 69. In 1984, 65 percent of 16- to 19-year-olds employed earned no more than four dollars an hour and 29 percent of 20- to 24-year-olds were in the same category.

In 1960, when 40 percent of



Doctor Bryant

young workers lacked high school diplomas, they earned merely 10 percent less than high school grads. In 1980, only 15 percent failed to graduate, but they earned 30 percent less than those who had high school degrees.

Since 1973, real earnings for those with high school diplomas have declined 28 percent. For those without, 42 percent and for college graduates six percent.

Family fragmentation

In 1955 half of all households in the United States were considered “typical,” with working-father house-wife mother and children; by 1985 the figure had fallen to seven percent. The American divorce rate, among the highest in the world, tripled between 1962 and 1981 and totaled over one million for the year 1986.

Sixty percent of today’s youngsters are likely to spend part of

their childhood in a single-parent family.

Adolescents alone

Teenagers require contact with adults in order to mature properly. Yet today, students interact with teachers only 20 percent of the time in classrooms that often are large, crowded and impersonal.

One survey stated that average teenagers share only five minutes a day exclusively with their fathers, and spend 22,000 cumulative hours watching television, twice that spent in the classroom.

Many teens are pretty much on their own.

Experimentation and risk-taking are essential to teenagers in enlarging their knowledge, finding their own individuality, testing their capabilities, developing self-discipline, challenging adult authority and developing autonomy.

Without this process, development will languish; teens may exhibit destructive qualities, misuse of alcohol and drugs, crime and delinquency, homicide and suicide, and other emotional disorders.

These are the sad situations this month’s issue of *Michigan Medicine* explores, with its special report designed to help Michigan physicians better manage the manifestations of youthful problems seen in medical practices.

Please read on for details in this *Michigan Medicine* on adolescence and its problems — A trying time and a time of trial.

In moderate depression and anxiety

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➡ First-week improvement in somatic symptoms¹
- ➡ 50% greater improvement with Limbitrol in the first week than with amitriptyline alone²

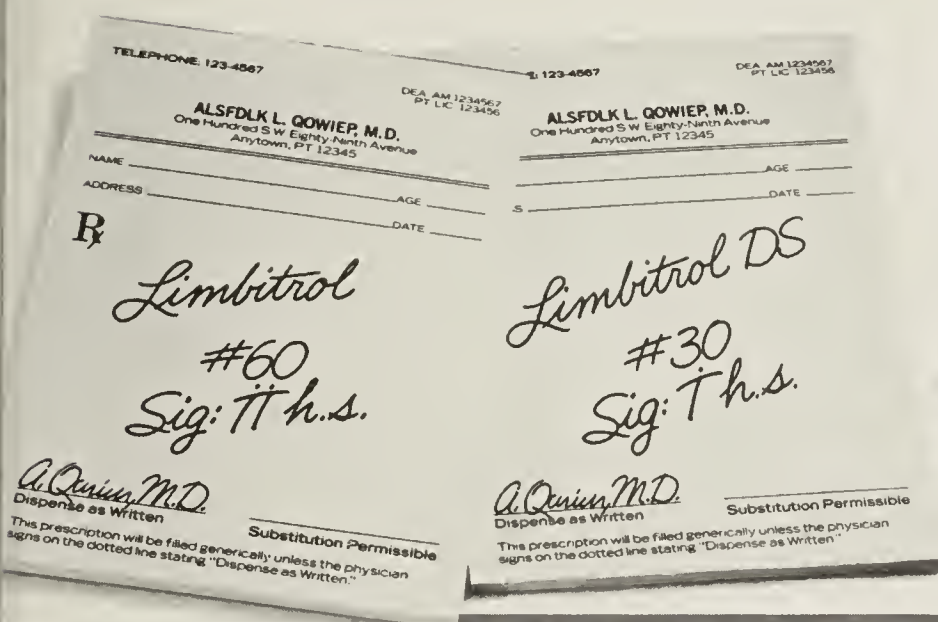
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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) ^(V)

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Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) ^(V)



References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

Limbitrol[®] Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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In the depressed and anxious patient

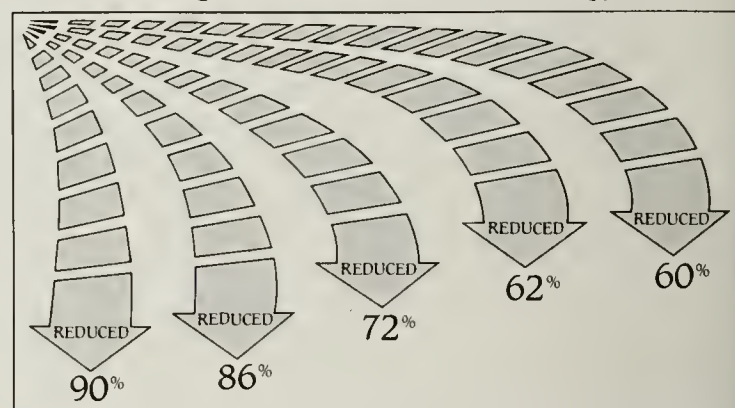
See Improvement In The First Week...¹

And The Weeks That Follow

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- ➡ First-week reduction in somatic symptoms¹

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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M I C H I G A N MEDICINE

OCTOBER 1988

AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

VOL. 87, No. 10

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Convention Special

**UPDATE IN '88:
From Basics
To Lasers**

*Michigan State Medical Society
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Hyatt Regency, Dearborn*



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MICHIGAN STATE MEDICAL SOCIETY

1988 Public Affairs

Leadership Conference

Wednesday, October 19, 1988

9:00 a.m. to 4:00 p.m.

Lansing Hilton Inn

Registration begins at 8:00 a.m.



"Taking Charge Begins Where it Ends"

Gordon H. Deckert, MD, FACP

David Ross Boyd Professor and Head of Department of
Psychiatry and Behavioral Sciences

University of Oklahoma Health Sciences Center

"Election '88"

Richard Wiener, Chair, Michigan Democratic Party

Spencer Abraham, Chair, Michigan Republican Party

BREAK

"Taking Charge" Breakout Sessions

Each of the following three breakout sessions will be presented twice - enabling conference participants to choose to attend two sessions. Plan to attend one session in the morning, and one immediately following lunch.

1. "Medicine and the Media"

Bruce B. Dan, MD

Senior Editor, Journal of the American
Medical Association and Medical Editor,
ABC News, Chicago

Tim Skubick

Senior Capital Correspondent for
Michigan Public Television, WJBK-TV
and WWJ Radio, Detroit

2. "Medical Economic Trends

Affecting Your Practice"

Donald Crandall, MD

Chairman, AMA Council on Medical
Service

John R. Higbee

Vice President, Government Business
Group

Blue Cross and Blue Shield of Michigan

3. "The Meeting will Come to Order"

Gordon Thomas, PhD

Professor Emeritus

Department of Communications
Michigan State University

LUNCH

"Taking Charge" Break out sessions repeat

BREAK

"One Physician Can Make a Difference: the MSMS Role in Promoting Off-Road Vehicle Safety"

B. Elliott Grysen, MD

MSMS Representative to the Michigan
State Safety Commission's Professional
Advisory Panel

"Professional Liability Twelve Years After the Doctor's Strike: A Retrospective"

Richard M. Corlin, MD

Speaker of the House
California Medical Association

"It Can't Happen Here: Medicare Assignment and Mandatory Health Insurance in Massachusetts"

Grant Rodkey, MD

Past President, Massachusetts Medical
Society and Vice-Chairman, AMA Council
on Medical Services

REGISTRATION FORM for "Taking Charge" (Please circle if you are a member, non-member or student)

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(Please print) (first) (initial) (last)

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City _____ State _____ Zip _____

County _____ Phone () _____

MSMS Member \$40
MSMS Student Member \$20
Non-Member \$45

Please indicate your choices for morning and afternoon breakout sessions.

Morning ☐ 1. "Medicine and the Media"

☐ 2. "Medical Economic Trends Affecting Your Practice"

☐ 3. "The Meeting will Come to Order"

Afternoon ☐ 1. "Medicine and the Media"

☐ 2. "Medical Economic Trends Affecting Your Practice"

☐ 3. "The Meeting will Come to Order"

Make checks payable to Michigan State Medical Society and mail to MSMS, Mary Anne Ford,
Box 950, East Lansing, MI 48826-0950.

M I C H I G A N M E D I C I N E

OCTOBER, 1988 VOL. 87, No. 10

Convention Special

"Update in '88" is the theme of this year's Annual Scientific Meeting, scheduled for November 8-10 at the Hyatt Regency Hotel in Dearborn. The ASM will provide a wealth of courses focusing on children, the family and the elderly, which should be of special appeal to family physicians. At the other end of the spectrum, the ASM will provide a full day's offerings in the use of lasers, which ends by detailing their application to six specialties. A new offering will be the first-ever ASM plenary session, featuring nationally-known AIDS expert James Curran, MD, of the Centers for Disease Control. To help make this year's ASM the best ever, *Michigan Medicine* is featuring 21 pages of information on the event, from course listings to clinical poster presentations to exhibitor information. Also included are guides to restaurants and entertainment in the Dearborn area. We hope attendees will find this "convention special" useful.

600

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Is another insurance crisis in store?

Thomas R. Berglund, MD, president and chairman of MPMLC, examines the medical liability insurance climate in Michigan

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Physician's File

This fifth in a series of reference reports for physicians addresses "Medically Unnecessary" Treatment: What Every Physician Should Know

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Included in this month's issue of *Michigan Medicine* is a copy of the most recent edition of Continuing Medical Education Requirements for Physicians Licensed By the Michigan Board of Medicine. We hope the booklet, prepared by the Michigan Department of Licensing and Regulation, will prove useful to readers.



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In next month's issue of *Michigan Medicine*:
A discussion of Harvard University's
Resource Based Relative Value Scale

Cover photo by: Hudson Creative Group, Inc.

Michigan: A great place to be

By Henry M. Domzalski, MD

Labor Day signaled the end of summer — the end of vacation and playtime — and a return to our usual pattern of life.

This past summer I had the opportunity to spend many pleasant days in various spots of the state — from north to south — and this experience reinforced long-held feelings that we are privileged, indeed, to live and work in this great state of Michigan.

Despite the many frustrations we encounter and attempt to overcome each day, Michigan is truly a wonderful place to be — with its incomparable natural beauty, spectacular scenery, season changes to enjoy, and for the most part, the company of industrious and friendly people.

Doctor Domzalski is chairman of the MSMS Committee on Publications.



Doctor Domzalski

“The MSMS Annual Scientific Meeting will be upon us soon.”

We are also privileged to have world-renowned academic excellence, with three outstanding medical schools within our borders. We also have a vast pool of talented practicing physicians. This academic excellence enables each of us — each year — the opportunity to update, rather painlessly, our knowledge and skills.

The MSMS Annual Scientific Meeting (slated for November 8-

10) will be upon us very soon. The ASM Planning Committee, under the able chairmanship of Joan Stryker, MD, began to assemble the program almost before the last meeting ended. With only a little effort on your part you can avail yourself of this expertise, renew old acquaintances, and perhaps make new ones. I hope to see you there. □

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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High blood pressure report available

The National Heart, Lung, and Blood Institute (NHLBI) is pleased to make available *The 1988 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure, (JNC IV)*.

The report was recently released by the coordinating committee of the National High Blood Pressure Education Program, a program sponsored by the NHLBI. This represents the fourth in a series of these reports which have provided physicians and other health professionals with updated therapy recommendations for more than a decade.

JNC IV reviews, updates, and expands the 1984 recommendations for controlling hypertension. The new report translates the results of the latest clinical trials to medical practice; addresses the needs of special populations; examines factors that influence the cost of care; and provides additional guidelines for managing high blood pressure in the presence of cardiovascular diseases and other co-existing medical conditions. It is intended as a guide for practicing physicians and other health professionals in their care of hypertensive patients and as a reference for those participating in the many community HBP control programs throughout the

Continued on page 640

Michigan State Medical Society

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UPDATE IN '88:

From Basics To Lasers



1988 MSMS ANNUAL SCIENTIFIC MEETING

November 8, 9, & 10

Hyatt Regency, Dearborn

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Update in '88

Annual Scientific Meeting

Education with a capital "C"

By Fred W. Bryant, MD
MSMS president

This month's *Michigan Medicine*, a "Convention Special," devotes 21 pages to the Society's biggest and grandest teaching enterprise, the Annual Scientific Meeting. A walk through the whys and wherefores of this formidable event should illustrate how education — with a capital "C" as in Continuing Medical Education — is a principal concern and objective of MSMS.



What and why

Composed of more than 50 courses, the Annual Scientific Meeting addresses a wide variety of subjects; most are of broad general interest, but some are geared to selective needs and specialized requirements. Duly approved in advance, and conveniently packaged in half-day units replete with illustrations, handouts, and opportunities to question the experts, all courses qualify for Category I CME credit and AAFP Prescribed credit (up to 19 hours for full attendance at the entire session). But beyond licensure requirements, physicians, perhaps the most educated people on earth, attend meetings in an attempt to satisfy their natural desire to excel, to be thorough and up-to-date.

Where and when

Beyond summer's distractions, but preceding winter's holidays and hazards, the Scientific Meeting is a perennial fall affair poised in the first half of November. Its three-day, mid-week format utilizes the Hyatt Regency Hotel in Dearborn, a substantial hostelry with the sundry facilities necessary to accommodate a program of this magnitude and complexity, and with easy accessibility to the expressways coursing through the heavy physician concentrations in southeastern Michigan. Regrettably, the geographic and population centers of the state do not coincide; the MSMS Annual Scientific Meeting Planning Committee is investigating the possibility of presenting the 10 most popular courses from this Annual Scientific Meeting as a sequel project in the spring at a yet-to-be-determined out-state locale.

Who and to whom

Numbering 200, the program speakers at the ASM typically are local notables (although some have national reputations); they are predominantly clinicians, with a sprinkling of pure teachers, theorists, and researchers. In clusters of three or four, often of varied background, specialty and geography,

they are sometimes referred to collectively as "multi-disciplinary," considered the ideal teaching team for these presentations. Course directors usually have special qualifications as moderators, perhaps lengthy experience or balanced perspectives.

Based on past experience total attendance at the three-day gathering will number approximately 1,000 — physicians, students, health professionals and guests; they will receive 7,500 hours of instruction.

Wealth of opportunity at a stingy price

From pediatrics to geriatrics, there is much to be gleaned from the rich sources of the ASM forum. Areas of general interest range from allergy and asthma to dermatology and the circulatory system. Subjects of social significance include the handicapped, physician recovery, the suicidal patient, and violence in the family.

It is customary to offer a continuum concept, referred to as alpha-omega (from first to last), which allows the pursuit of similar courses arranged in series. This year's tandem offerings encompass **Rehabilitation of the Elderly: Keeping Older Patients on Their Feet, Financing Long-Term Care: Impact on Patients and Providers**, which features national and state legislators as part of the course panel; **Lasers: Today's Medical Tools** (Part I and II), which will explain how lasers apply to various specialties, and a timely double session on **AIDS**: one an AIDS update presented by the Michigan Department of Public Health and the MSMS Public Health Liaison Committee, the other an extraordinary and timely plenary program featuring James Curran, MD, formerly of Michigan, now of The Centers for Disease Control in Atlanta. (This program is without charge for the hour's credit and continental breakfast. Hard to beat!)

As a matter of fact, all noon deli lunches are free to all paid registrants. Course rates, too, are a bargain — \$25 for a half-day course for MSMS active members, \$12 for retired, \$15 for residents — and free to students.

A display of 20 separate poster presentations attended by their creators, all of whom will be on hand to offer explanations and respond to questions, will line the entrance way. Special programs will take place each evening. The exhibit hall will accommodate guest exhibits by the Michigan Branch of the American Cancer Society, Michigan Health Council, World Medical Relief, the Michigan Board of Licensure and Regulation, and Mediation and Arbitration, as well as 70 commercial booths.

It's worth attending

Many people work long and hard to create, maintain and augment the MSMS educational posture. They are working in your behalf. Why not try a program?

Capsule Schedule



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn

TUESDAY, NOVEMBER 8

7:30 AM

Great Lakes Exhibit Center Open

Registration

8:30 AM

Concurrent Scientific Courses (run until Noon)

- Hyperlipidemia
- Coronary Syndromes
- Arthritis
- Basic Cardiac Life Support
- Ob/Gyn Pathology
- Hypertension
- Perioperative Problems
- Venous Disorders
- Sinus Disease

Clinical Poster Display (all day)

12 Noon

Luncheon for All Registrants

Michigan Occupational Medical Association
(Luncheon/Board Meeting)

1:00 PM

Board Meeting and Luncheon

Michigan Chapter of American Academy of Pediatrics

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- Children with Chronic Illness
- Neuroradiologic Applications of MRI
- Clinical Toxicology
- Hematology
- Family Counseling Skills
- Neuromuscular Diseases
- Physicians Recovery Network
- Pulmonary Infections
- Rehabilitation of the Elderly

6:00 PM

Reception/Dinner/Program

Michigan Occupational Medicine Association,
Detroit Michigan

Occupational Health Nurses

Association and the Michigan Industrial
Hygiene Society

Reception

MSMS ASM Planning Committee

WEDNESDAY, NOVEMBER 9

7:00 AM

"Early Bird" Plenary Session on AIDS

Hubbard Ballroom (Coffee & Rolls included)

7:30 AM

Great Lakes Exhibit Center Open

Registration

8:30 AM

Clinical Poster Display (all day)

Concurrent Scientific Courses (run until Noon)

- Arterial Blood Gases
- Acute Visual Problems
- Basic Cardiac Life Support
- Cancer Prevention and Detection
- Drug Testing
- Diagnostic Ultrasound
- Estrogen Replacement Therapy
- Pregnancy in Diabetes Mellitus
- The Handicapped Patient

9:00 AM

Board Meeting/Luncheon

Michigan Allergy Society

12 Noon

Lunch for All Registrants

Luncheon

Specialty Society Presidents

Luncheon

Sponsored by MSMS Committee on Concerns
of Women Physicians

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- AIDS Update
- Allergy and Asthma
- Back Pain
- Pediatric Problems
- Otolaryngologic Problems
- Controversies in Anesthesiology
- Dermatology Update
- Radiology
- Physician's Office Laboratory
- Violence in the Family

6:00 PM

Reception/Dinner/Program

Michigan Otolaryngological Society

Reception/Cash Bar

Michigan State University

College of Human Medicine

Open House

University of Michigan Medical School

Reception

Wayne State University Medical Alumni

THURSDAY, NOVEMBER 10

7:30 AM

Great Lakes Exhibit Center Open

Registration

8:30 AM

Concurrent Scientific Courses (run until Noon)

- The Paralyzed Face
- Basic Cardiac Life Support
- Cardiovascular Disease in Women
- Sleep Apnea
- Gastrointestinal Endoscopy
- Lasers (Part I)
- Nephrologic Problems
- The Suicidal Patient

12 Noon

Lunch for All Registrants

1:30 PM

Concurrent Scientific Courses (run until 5.00 p.m.)

- Urinary Incontinence
- Plastic Surgical Research
- Financing Long-Term Care
- Lasers (Part II)
- Gastrointestinal Tract
- Nuclear Medicine
- Thyroid Patient
- Pediatric Emergencies
- Sports Medicine
- Colorectal Surgery

5:30 PM

Board Meeting/Reception/Dinner/Program

Michigan Academy of Physical Medicine & Rehabilitation

6:30 PM

Dinner/Program

Michigan Society of Colon & Rectal Surgeons

Schedule of Special Events

■ Clinical Poster Displays

(all day)

Tuesday and Wednesday, November 8-9

■ "Early Bird" Plenary Session on AIDS

with CDC expert from Atlanta

(Coffee & Rolls included)

Wednesday, November 9 at 7:15 a.m.

■ Michigan Academy of Physical Medicine & Rehabilitation

Board Meeting/Reception/Dinner/Program

Thursday, November 10 at 5:30 p.m.

■ Michigan Allergy Society

Board Meeting at 9:00 a.m.

Luncheon at 12 Noon

Wednesday, November 9

■ Michigan Chapter of American Academy of Pediatrics

Board Meeting/Luncheon

Tuesday, November 8 at 1:00 p.m.

■ Michigan Occupational Medical Association

Board Meeting/Luncheon

Tuesday, November 8 at 12 Noon

■ Michigan Occupational Medical Association, Detroit Michigan Occupational Health Nurses Association and the Michigan Industrial Hygiene Society

Reception/Dinner/Program

Tuesday, November 8 at 6:00 p.m.

■ Michigan Otolaryngological Society

Reception/Dinner/Program

Wednesday, November 9 at 6:00 p.m.

■ Michigan Society of Colon & Rectal Surgeons

Reception/Dinner/Program

Thursday, November 10 at 6:30 p.m.

■ Michigan State University College of Human Medicine

Reception/Cash Bar

Wednesday, November 9 at 6:00 p.m.

■ MSMS ASM Planning Committee

Reception/Buffer

Tuesday, November 8 at 6:00 p.m.

■ MSMS Committee on Concerns of Women Physicians

Luncheon

Wednesday, November 9 at 12 Noon

■ Specialty Society Presidents

Luncheon

Wednesday, November 9 at 12 Noon

■ University of Michigan Medical School

Open House

Wednesday, November 9 at 6:00 p.m.

■ Wayne State University Medical Alumni

Reception

Wednesday, November 9 at 6:00 p.m.

Choose from 55 Category I Courses



1988 MSMS ANNUAL
SCIENTIFIC MEETING
November 8, 9, & 10
Hyatt Regency, Dearborn

Tuesday morning, November 8

All courses run from 8:30 to noon with half-hour break

☐ A Practical Approach to Hyperlipidemia

PRESENTED BY: Lipid Clinic, Henry Ford Hospital

This course is designed to provide primary care physicians with an understanding of cholesterol as a risk factor, the indications for intervention and the ability to initiate treatment in uncomplicated cases.

COURSE DIRECTOR: Dorothy M. Kahkonen, MD, Co-Director Lipid Clinic, Henry Ford Hospital, Detroit

☐ Acute Coronary Syndromes: Mechanical & Medical Interventions

PRESENTED BY: Department of Cardiovascular Medicine, Henry Ford Hospital

This course with four presentations will provide to internists, clinicians and cardiologists current information in regard to the mechanisms and potential therapeutic interventions in patients with acute coronary syndromes. The particular role of thrombolytic therapy, angioplasty, calcium and beta adrenergic block agents will be discussed. One hour will be reserved for questions and discussion of these topics with the audience.

COURSE DIRECTOR: Sidney Goldstein, MD, Division of Cardiovascular Medicine, Henry Ford Hospital, Detroit

☐ Arthritis in the Office

PRESENTED BY: Michigan Rheumatism Society

This course is for primary physicians with an office practice. Each speaker will begin with a half-hour presentation and then open the discussion to audience questions. The course will cover: 1) use of the laboratory in the rheumatic diseases; 2) technique of joint aspiration and the ordering of synovial analysis; 3) soft tissue rheumatism and its treatment; 4) Recognition and care of reactive arthritis. This course will improve the ability of primary physicians to care for rheumatic complaints in an expeditious and cost-efficient manner.

COURSE DIRECTOR: Joseph J. Weiss, MD, Private Practice, Livonia; Michigan Rheumatism Society

☐ Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

The course will include lectures and practical stations for teaching Basic Cardiac Life Support according to the new American Heart Association guidelines. The practical session will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Director, Emergency Medical Services, St. Lawrence Hospital, Lansing

☐ Current Concepts in Gynecological and Obstetrical Pathology

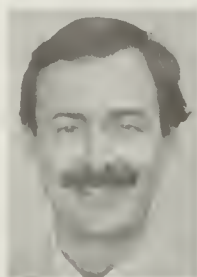
PRESENTED BY: Division of Anatomic Pathology, Hutzel Hospital and Wayne State University School of Medicine

The course will consist of three 45 minute lectures covering topics of current interest in gynecologic and obstetrical pathology. We will include a clinicopathologic discussion of current controversy in endometrial hyperplasia and neoplasia, the use of the cytobrush in the diagnosis of cervical intraepithelial neoplasia (including human papillomavirus-associated lesions), and clinicopathologically important disorders of the placenta. Additionally, two short case presentations will cover two relatively new and clinicopathologically interesting entities of the female genital tract. The course is geared toward practicing pathologists and obstetrician-gynecologists and aims to clarify some of the controversial concepts in the proposed topics.

COURSE DIRECTOR: W. Dwayne Lawrence, MD, Assistant Professor, Department of Pathology, Wayne State University School of Medicine and Chief, Department of Anatomic Pathology, Hutzel Hospital, Detroit

☐ Hypertension - Current Therapeutic Update

PRESENTED BY: MSMS Section on Clinical Pharmacology and Therapeutics and The Upjohn Company



Blumenkranz



Breiner



Burkman



Curran



Davies



Desguin



Ditmars

In this course, an overview of therapy of hypertension will be presented with particular reference to the initial hypertensive workup, who to treat, definition and description of step therapy, and what is on the horizon for the treatment of hypertension. A panel discussion with the audience will be held at the end of the program.

COURSE DIRECTOR: George L. Royer, Jr., MD, The Upjohn Company, Kalamazoo

☐ Perioperative Problems for the Primary Care Physician

PRESENTED BY: Department of Medical Education, Oakwood Hospital, Dearborn

Primary care physicians are often called upon to assist in the pre and post operative care of their patients who undergo surgery. This course will review several major aspects of perioperative care including perioperative cardiopulmonary evaluation, perioperative nutritional management and principles of surgical antimicrobial prophylactics. The evaluation and management of common postoperative complications including jaundice and wound infections will also be discussed.

COURSE CO-DIRECTORS: Nicholas J. Lekas, MD, Director, Internal Medicine Residency and Chief, Department of Infectious Disease, Oakwood Hospital, Dearborn and Lyle D. Victor, MD, Chief, Department of Pulmonary Medicine, Oakwood Hospital, Dearborn

☐ Venous Disorders: Current Management

PRESENTED BY: Department of Surgery, University of Michigan Medical School

This review will provide the latest information on the etiology, diagnosis, and management of acute deep vein thrombosis. In addition, there will be discussion of the role of lytic therapy and the use of the Greenfield filter to prevent pulmonary embolism. The surgical management of chronic venous insufficiency and congenital venous disorder will also be reviewed.

COURSE DIRECTOR: Lazar J. Greenfield, MD, Professor and Chairman, Department of Surgery, University of Michigan Medical School

☐ Wiping Out Sinus Disease

PRESENTED BY: Department of Otolaryngology, Henry Ford Hospital, Detroit

This course will provide a general approach to evaluation and treatment of patients with nasal and sinus disease. Nasal anatomy and physiology will be presented in relation to clinical complaints and the effects of allergy on sinus and pulmonary disease will be discussed. Sinus endoscopy will be discussed and a video tape presented.

COURSE DIRECTOR: Kathleen L. Yaremchuk, MD, Division Head, Division of Otolaryngology, Henry Ford Hospital Fairlane, Dearborn

Tuesday afternoon, November 8

All courses run from 1:30 to 5 p.m. with half-hour break

☐ Children with Chronic Illness: Shared Needs and Concerns

PRESENTED BY: Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

The purpose of this course is to explore solutions to the problems of families having children with chronic illness. The usefulness of a multiprofessional approach and its application to primary, office-based care will be demonstrated. The format will utilize typical case histories, preliminary panel discussions followed by extensive involvement of the audience in generating ideas, questions, commentaries, sources of information and sources of support. The goal of the session is to assist the primary care physician in increasing his/her interest, skills and

confidence in managing the problems of the child and family when the child has a chronic illness.

COURSE DIRECTOR: Barbara W. Desguin, MD, Assistant Professor, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

☐ Clinical Neuroradiologic Applications of Magnetic Resonance Imaging

PRESENTED BY: Department of Radiology, University of Michigan Medical School



Ehrinpreis



Fachnie



Falit



Finch



Freitas



Fujita



Gabrielsen

This course will provide practical information on neuroradiologic applications of Magnetic Resonance Imaging (MRI), which are considered helpful to physicians in clinical practice. MRI has proven to be very important for evaluation of a variety of abnormalities involving the brain, and the head in general, as well as the spine and spinal cord. This rather new imaging modality is still evolving quite rapidly. The current status of MRI including its advantages and disadvantages compared to other imaging modalities, especially CT, will be emphasized.

COURSE DIRECTOR: Trygve O. Gabrielsen, MD, Professor, Department of Radiology and Director, Division of Neuroradiology, University of Michigan Medical School

Clinical Toxicology for the Front Line Physician

PRESENTED BY: Michigan Occupational Medical Association

This course will instruct primary and consulting physicians in the application of basic principles of toxicology to the diagnosis, management and prevention of illness. Principles of toxicology will be discussed in clinical terms familiar to physicians. Sources of information for diagnosing and treating suspected poisonings will be discussed and illustrated with case histories. Detailed descriptions of the signs and symptoms of overdose with central nervous system toxins will be discussed. Time will be reserved for questions and discussion of participants' own cases.

COURSE DIRECTOR: Elizabeth E. Gresch, MD, The Dow Chemical Company, Midland

Common Problems in Hematology

PRESENTED BY: Department of Medicine, Section of Hematology/Oncology, Michigan State University College of Human Medicine

Some common hematological disorders will be presented and discussed, and include the following topics: a) evaluating abnormal coagulation screening results, b) hemochromatosis - the overlooked diagnosis, c) investigating the patient with increased hemoglobin values, d) evaluating anemia and thrombocytopenia. Audience participation is welcomed and opportunity for case discussion will be provided.

COURSE DIRECTOR: John A. Penner, MD, Professor, Department of Medicine and Chief, Section of Hematology/Oncology, Michigan State University College of Human Medicine

Family Counseling Skills for Office Practice

PRESENTED BY: Department of Family Practice, University of Michigan Medical School

The purpose of this course is to acquaint or re-acquaint primary care physicians with the knowledge and skills necessary for the assessment and brief office treatment of family dysfunction. Upon completion, each attendee should be able to: 1) understand the theory and principles relevant to family treatment; 2) identify the patient care issues that would indicate a need to assess the family system; 3) know how to convene a family; 4) apply family counseling techniques to aid families in their attempts to change; and 5) recognize those families that can be treated by the family care physician and those that require referral. Case presentations, including videotaped vignettes, will focus on patients who present with multiple somatic symptoms, children with recurrent illnesses and families adjusting to traumatic illness/injury.

COURSE DIRECTOR: S. Margaret Davies, MD, Assistant Professor, University of Michigan Family Practice Center, Chelsea

Neuromuscular Diseases

PRESENTED BY: Department of Neurology, Wayne State University School of Medicine

This course is designed for primary physicians, internists and pediatricians, but should prove useful for neurologists, and physiatrists as well. The purpose is to present a logical approach to neuromuscular diseases. One-hour lectures will emphasize the current approaches to diagnosis and management of diseases of muscle, the neuromuscular junction and peripheral nerve including special considerations in children. The role and limitations of laboratory evaluation including EMG/NCN will be discussed.

COURSE DIRECTOR: Robert P. Lisak, MD, Professor and Chairman, Department of Neurology, Wayne State University School of Medicine and Chief, Department of Neurology, Harper Hospital, Detroit

Physicians Recovery Network: Help a Friend

PRESENTED BY: MSMS Physicians Recovery Network

The purpose of this course is to provide practical information and methods to identify, diagnose, and manage patients suffering from alcoholism and drug addictions. Through lectures and didactic presentations with slides and case study, techniques will be provided that can be used in the office or hospital by generalist or specialists. The application to colleagues will be addressed. Participants questions and cases will be discussed in addition to the lecture.

COURSE DIRECTOR: Gerald A. VanderVoord, MD, Medical Director, MSMS Physicians Recovery Network, East Lansing



Goldstein



Greenbaum



Greenfield



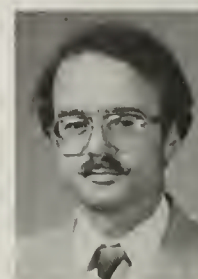
Gresch



Gruskin



Henry



Kadro

Pulmonary Infections

PRESENTED BY: Michigan Thoracic Society and Michigan Chapter, American College of Chest Physicians

This course will present a broad review with emphasis on new developments regarding pulmonary infections, including information on clinical presentation, diagnostic approaches, and treatment modalities. The afternoon will be divided up into four segments consisting of problems with community acquired pneumonia, hospital acquired pneumonia, infection in chronic obstructive pulmonary diseases (chronic bronchitis, asthma, cystic fibrosis), and pneumonia in the immunocompromised host. The material will be directed toward the general practitioner and ample time for questioning will be provided.

COURSE DIRECTOR: Richard H. Simon, MD, Assistant Professor, Department of Pulmonary & Critical Care Medicine, University of Michigan Medical Center

Rehabilitation of the Elderly: Keeping Older Patients on Their Feet

PRESENTED BY: MSMS Committee on Aging

This course will illustrate to primary physicians with a large geriatric practice the potential for maintaining function and independence in elderly patients with common physical disabilities. Evaluation of the patients to determine suitability for rehabilitation and methods for mobilizing patients after lower extremity fractures, strokes, and degenerative arthritis will be discussed. Special precautions and considerations for the frail elderly will be emphasized.

COURSE DIRECTOR: Frank S. Blumenthal, MD, Director, Geriatric Unit, Rehabilitation Institute, Detroit

First Time Ever!

"Early Bird" Plenary Session

**Wednesday, November 9,
Hubbard Ballroom**

National Perspective on AIDS



James Curran, MD, AIDS Program Director

Centers for Disease Control, Atlanta

Continental Breakfast at 7:00 a.m.

Presentation at 7:15 a.m.

As of August 1988, over 69,000 cases of AIDS have been reported since 1981, 29,674 in the past year alone. Black and Hispanic adults and children have reported rates two to eighteen times higher than whites. This can be largely attributed to higher reported rates in Black and Hispanic IV drug abusers, their sex partners and infants. In 1986, reported AIDS deaths increased adult male and female mortality in the United States by an estimated 0.7 and 0.07% respectively with much greater increases in selected groups or areas of the country. The greatest variation in HIV seroprevalence (0 to 70%) has been found in surveys of IV drug abusers, while surveys of homosexual men reveal seroprevalence rates of 20 to 50%. HIV seroprevalence ranged from 0 to 2.7% in limited STD clinic surveys of heterosexual men and women without a history of IV drug abuse or known sexual contact with persons at increased risk. The modes of HIV transmission are now well understood, but a large amount of biologic variability in efficiency of transmission remains to be explained. The period between initial infection with HIV and the development of AIDS is variable, but the risk of disease progression increases with duration of infection.

Come early, have breakfast and hear Doctor Curran discuss the national perspective on AIDS and where Michigan is in the picture. There is no fee for this program and it offers 1 hour of Category I CME credit.



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn



Kahkonen



Kling



Lawrence



Lawson



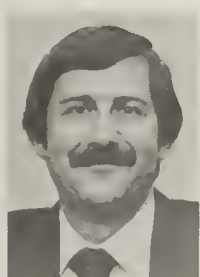
Lepard



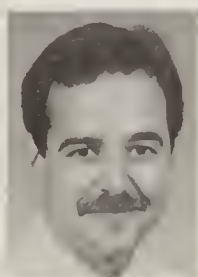
Mackechnie



McMahon



Migdal



Niparko



O'Brien



Orr



Penner



Perlman



Romano

Wednesday morning, November 9



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn

All courses run from 8:30 to noon, with half-hour break

☐ **A Practicum on Arterial Blood Gases**

PRESENTED BY: Department of Medicine, Michigan State University College of Human Medicine and Ingham Medical Center, Lansing

The course will consist of a description of oxygen toxin and how to evaluate it clinically, measures of ventilation and acid/base balance and their clinical evaluation, and a suggested method to evaluate patients by blood gas analysis. The second half of the program will be a preceptored workshop on analyzing arterial blood gas values.

COURSE DIRECTOR: Samuel M. McMahon, MD, Professor, Department of Medicine, Michigan State University College of Human Medicine

☐ **Acute Visual Problems**

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is designed to help primary care internists, pediatricians, family practitioners, and emergency physicians understand and evaluate acute visual problems. The common complaints of acute visual loss, blindness, double vision, and abnormal pupillary findings will be reviewed. History and physical examination will be emphasized as well as how to separate potentially dangerous from benign conditions in the outpatient setting using a minimum of tests and laboratory studies and maximum of intelligent thought. At the conclusion of this course the participants will be able to understand the physiology of vision and various disease entities which may cause interference with good vision. The participants will also gain command of the appropriate diagnostic tests and when to perform them emergently.

COURSE DIRECTOR: Gregory L. Henry, MD, FACEP, Course Coordinator, Michigan Chapter, American College of Emergency Physicians

☐ **Basic Cardiac Life Support**

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

The course will include lectures and practical stations for teaching Basic Cardiac Life Support according to the new American Heart Association guidelines. The practical session will include hands-on teaching of cardiopulmonary resuscitation,

obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Director, Emergency Medical Services, St. Lawrence Hospital, Lansing

☐ **Cancer Prevention and Detection for Primary Care Physicians**

PRESENTED BY: Michigan Division, American Cancer Society

The purpose of this course will be to update primary care physicians regarding the latest advances, in ambulatory office cancer control as related to prevention and early diagnosis. The major sites addressed will be breast, colorectal and lung through a lecture/discussion format in three one-hour sessions.

COURSE DIRECTOR: Leif George Suhrlund, MD, Professor, Department of Medicine, Michigan State University College of Human Medicine

☐ **Current Status of Drug Testing**

PRESENTED BY: MSMS Section on Clinical Pharmacology and Therapeutics and the Upjohn Company

Testing for both legal and illegal drugs by random or for discernible cause is more complex than the media might lead one to believe. Medical methodological, legal, political, and cost benefits of drug testing will be explored. Adequate time for questions and answers and a panel discussion with the experts will be made available for the audience.

COURSE DIRECTOR: George L. Royer, Jr., MD, The Upjohn Company, Kalamazoo

☐ **Diagnostic Ultrasound in Modern Medicine**

PRESENTED BY: Department of Obstetrics and Gynecology, Imaging, Hutzel Hospital, Detroit

This course, led by two nationally known ultrasound experts, will provide an overview for primary and consulting physicians of the new roles ultrasound imaging has in medical practice today. The topics to be covered include a survey of sophisticated prenatal and neonatal diagnostic techniques and therapeutic modalities, the impact of color flow ultrasound and adult endosonography.



Royer



Sienko



Sonda



Suhrlund



Vander Voord



Victor



Weiss

COURSE DIRECTOR: Alan J. Sacks, MD, Division of Obstetrics and Gynecology Imaging, Hutzel Hospital, Detroit

Estrogen Replacement Therapy

PRESENTED BY: MSMS Committee on Concerns of Women Physicians

This course, through a lecture and slide presentation format, will discuss the changing perspective of menopause. The course will present information on hormonal changes, steroid receptors, target organs and the menopause syndrome. Other information will include new treatment and monitoring approaches, the choice of estrogen and the choice of path of administration. Time will be reserved for questions and discussion of participants' own cases.

COURSE DIRECTOR: Dawn E. Springer, MD, Chairman, MSMS Committee on Concerns of Women Physicians, East Lansing

Planning For Pregnancy in Diabetes Mellitus

PRESENTED BY: Department of Metabolism, Henry Ford Hospital

The course is intended for internists, family practitioners, obstetricians, and pediatricians. Diabetes affects four percent of pregnancies. The practitioner will hear lectures (2/3 of time) and discussion (1/3 of time) pertaining to preconception and metabolic control, gestational diabetes mellitus, medical and obstet-

rical management. The 1988 Michigan Department of Public Health Guidelines will be available.

COURSE DIRECTOR: J. David Fachnie, MD, FACP, Clinical Assistant Professor, Department of Internal Medicine, University of Michigan Medical School; Senior Staff Physician, Henry Ford Hospital

The Handicapped Patient in Society and Private Practice

PRESENTED BY: Sinai Hospital Hearing Impaired Professional Services Clinic (SHHIPS Clinic), Sinai Hospital

This course will provide practical information about the special problems of the handicapped patient. In addition to caring for the medical needs of the handicapped patient the primary care physician is frequently asked for help in dealing with special problems. The family of the handicapped child will want to know what approaches should be used in raising their child, what resources are available in our society and what are their rights for services and help. Handicapped adults will need information about adjustments to society and the means of accessing services. Our society has many misconceptions about the handicapped individual. Understanding the special needs and unique problems of these patients will increase your effectiveness in caring for them. Course materials will include lists of resources for a wide variety of handicaps and special needs.

COURSE DIRECTOR: Keith Lepard, MD, Medical Director, SHHIPS Clinic, Detroit

Wednesday afternoon, November 9

All courses run from 1:30 to 5 p.m. with half-hour break

AIDS Update

PRESENTED BY: Michigan Department of Public Health and the MSMS Public Health Liaison Committee

The opening presentation will provide a review of the HIV, including its structure, life cycle, targets, body-fluid distribution and transmission; the medical aspects of pediatric AIDS will follow. The ensuing presentation will focus on the symptomology of HIV infection, the diagnosis of AIDS, the treatment of AIDS and HIV-related conditions, and nosocomial transmission of HIV. The final presentation will discuss the state and local public health effort, including AIDS testing and education, prospects on partner notification and resources available to the clinical community from public health agencies. The course will

conclude with comments from Doctor Curran and a question and answer session.

COURSE DIRECTOR: Dean G. Sienko, MD, Michigan Department of Public Health, Lansing

Allergy and Asthma Update

PRESENTED BY: Michigan Allergy Society

This course is designed for both primary care physicians and allergists. Three areas will be covered in half-hour blocks. The differential diagnosis between allergic and nonallergic rhinitis and its management will be reviewed as well as the management of allergy and asthma problems in our increasingly health-conscious patients. Discussions will include the proper



Yaremchuk



Zingas

workup of the child with more than the usual number of infections and ample time will be left for questions from the audience.

COURSE DIRECTOR: Hugh L. N. MacKechnie, MD, President, Michigan Allergy Society, Detroit

Back Pain: Returning to Work

PRESENTED BY: Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine and Rehabilitation Institute.

When a patient with back pain is told at treatment onset that he needs to return to work and that work is an integral element of the treatment, not a product of a pain management program, a higher percentage do return to work and remain working. This process whereby the patient with back pain learns to return to productive status, and to accept responsibility for his own care, will be described. The primary care physician will be taught to diagnose the common causes of back pain, the appropriate physical and psychosocial management, to take a work history, and prescribe a return to work program. The physician will learn to become more concerned with functional outcome than with symptomatic relief, and the preventive measures which can be taken in the work place to facilitate return to work and to keep the patient working safely.

COURSE DIRECTOR: Harry O. Ingberg, MD, Associate Professor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine

Common Office Pediatric Problems

PRESENTED BY: Michigan Chapter, American Academy of Pediatrics

This course, designed for family practitioners and pediatricians, will refresh your knowledge of common ambulatory pediatric problems. The four featured experts, using slides and printed hand-outs, will speak on indications for newer vaccines and antibiotics, management of chronic abdominal pain, preparation and interpretation of office hematologic tests, and management of recurrent urinary tract infections. Ample time will be reserved for questions and audience discussion.

COURSE DIRECTOR: Stanford A. Singer, MD, Michigan Chapter, American Academy of Pediatrics, Southfield

Common Otolaryngologic Problems in Children

PRESENTED BY: Michigan Otolaryngologic Society

This course will provide an overview of current methods of evaluating and managing ear, sinus and upper airway diseases in children. We will provide detailed discussions of therapeutic approaches to otitis media, rhinosinusitis and airway injury in the pediatric population. The long term effects of these disorders on language and speech development will be addressed.

COURSE DIRECTOR: John K. Niparko, MD, Assistant Professor, Department of Otolaryngology, University of Michigan Medical School

Current Controversies in Anesthesiology

PRESENTED BY: Department of Anesthesiology, University of Michigan Medical School

This course, designed for anesthesiologists and surgeons, uti-

lizes four 45 minute lectures and will consider four controversial topics in current anesthesiology practice. Leading off will be a discussion of the management of the patient with a difficult airway requiring anesthesia. Additional topics include consideration of the advantages of regional as opposed to general anesthesia, the role of narcotics in patients with chronic pain syndromes and, finally, an update on the longstanding colloid-crystalloid controversy with emphasis on some of the newer colloid osmotic blood volume expanders. Sufficient time will be allowed for questions and discussion.

COURSE DIRECTOR: Jay S. Finch, MD, Professor and Chairman, Department of Anesthesiology, University of Michigan Medical School

Dermatology Update 1988

PRESENTED BY: Michigan Dermatological Society

This course will provide an update on a number of timely dermatologic topics including: 1) The clinical spectrum of human papillomavirus disease; 2) An update on the use of retinoids in dermatology; 3) Connective tissue disease in children; 4) The treatment of dermatologic emergencies; and 5) Syphilis in the 1980's emphasizing atypical presentations and treatment modifications in HIV positive patients. The series of lectures with time allowed for discussion will be primarily of interest to dermatologists, internists and family practice physicians.

COURSE DIRECTOR: Margaret C. Douglass, MD, Department of Dermatology, Henry Ford Hospital, Detroit

Radiology for Clinicians

PRESENTED BY: Department of Radiology, Wayne State University School of Medicine

This course, through four presentations, will provide primary and consulting physicians practical information in the approach of common clinical problems using various diagnostic modalities. Indications and uses of diagnostic ultrasonography in the evaluation of various abdominal and pelvic abnormalities will be presented. Radiological complications of drug abuse will be demonstrated. The role of nuclear medicine as a diagnostic tool will be presented. Computed tomography (CT) and magnetic resonance imaging (MRI) will be compared in the evaluation of common neurological problems. A short question and answer period will follow.

COURSE CO-DIRECTORS: George A. Kling, MD, Associate Professor and Chairperson, Department of Radiology, Harper-Grace Hospitals, Harper Division, Detroit and Alkis P. Zingas, MD, Clinical Assistant Professor, Department of Radiology, Harper-Grace Hospitals, Harper Division, Detroit

The Physician's Office Laboratory in 1988

PRESENTED BY: Michigan Society of Pathologists

The course presents, through lectures and demonstrations, information on quality assurance (QA) in the clinical laboratory in general, and in the physicians office laboratory in particular. Quality assurance programs for the physician's office, provided jointly through the American Academy of Family Physicians, the American Society of Internal Medicine, and the College of American Pathologists are highlighted.

COURSE DIRECTOR: Noel S. Lawson, MD, Associate Pathologist, Department of Pathology, St. John Hospital, Detroit

Violence in the Family

PRESENTED BY: Michigan Psychiatric Society

Every clinically active physician will gain practical knowledge about the various forms of violence to and from family members. The panel of four specialists in this area will devote about 1/2 hour each for clinically oriented presentations. This will allow ample time for discussion and questions with the audience, with an orientation towards prevention and problem solving.

Some of the topics covered will be violence between spouses, verbal abuse, murder, non-physical abuse to children, sexual abuse, etc. Understanding, solutions and prevention are the functions of this panel.

COURSE DIRECTOR: Sander J. Breiner, MD, FAPA, Assistant Professor, Department of Psychiatry, Wayne State University School of Medicine; Associate Professor, Department of Psychiatry, Michigan State University College of Human Medicine

Thursday morning, November 10



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn

All courses run from 8:30 to noon, with half-hour break

Animation of the Paralyzed Face

PRESENTED BY: Michigan Academy of Plastic Surgeons

This course will provide practicing plastic surgeons with a historical review, current research and state-of-the-art approach to animation of the paralyzed face. The basic surgical research into muscle transplantation with clinical correlation will be presented by Dr. Ronald Zuker, our invited guest from the Toronto Hospital for Sick Children. The University of Michigan Facial Muscle Registry will be introduced.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Division Head, Division of Plastic Surgery, Henry Ford Hospital, Detroit

COURSE DIRECTOR: Ronald T. Burkman, MD, Chairman, Department of Obstetrics/ Gynecology, Henry Ford Hospital, Detroit

Current Concepts In Sleep Apnea

PRESENTED BY: Department of Otolaryngology, Henry Ford Hospital

This course presents current concepts of sleep apnea and clinical approaches to diagnosis and treatment in both adults and children. It considers basic sleep physiology, pathophysiology of obstructive sleep apnea syndrome (OSAS), sleep laboratory evaluation (polysomnography), and medical evaluation and management. The first part is designed to familiarize practicing physicians with basic sleep physiology, laboratory evaluation, and medical evaluation and management. This includes differential diagnosis of hypersomnolence and cardiopulmonary complications as well as current trends in medical treatment (drug therapy and C-PAP). The second part includes information about clinical implications of snoring and current surgical management. Sleep-related airway problems of children will be discussed by a pediatric otolaryngologist.

COURSE DIRECTOR: Shiro Fujita, MD, ENT Consultant, Sleep Disorders Center, Henry Ford Hospital, Detroit

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

The course will include lectures and practical stations for teaching Basic Cardiac Life Support according to the new American Heart Association guidelines. The practical session will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Director, Emergency Medical Services, St. Lawrence Hospital, Lansing

Gastrointestinal Endoscopy and the Generalist

PRESENTED BY: Division of Gastroenterology, Wayne State University School of Medicine and Harper-Grace Hospitals

This course will update the practicing physician on the indications, contraindications and utility of G.I. Endoscopy as a diagnostic modality, a cancer surveillance technique and as a therapeutic modality. Conventional and unconventional clinical situations will be covered to expand the clinician's knowledge of these powerful clinical tools. Ample time for questions will follow the series of half-hour lectures.

COURSE DIRECTOR: Murray N. Ehrinpreis, MD, Assistant Professor, Department of Internal Medicine, Wayne State University School of Medicine and Attending Gastroenterologist, Harper-Grace Hospitals, Detroit

Cardiovascular Disease in Women: The Pill and Estrogen Replacement

PRESENTED BY: Michigan Chapter, American College of Obstetricians and Gynecologists and Henry Ford Hospital

This course, designed for all practitioners providing care to women, will review the important issues relative to cardiovascular disease in women and will review the role of oral contraceptives and menopausal hormone replacement therapy in affecting the risk of cardiovascular disease. The format will consist of two 45-minute lectures on the topics, followed by case presentations. Time also will be reserved for questions and discussion of participants' own cases.

Lasers: Today's Medical Tools (Part I)

PRESENTED BY: Michigan Ophthalmological Society

This course, first of a two-part session on the use of lasers in medicine today, will focus on three areas of laser surgery. The course is designed to acquaint health professionals with an overview of laser applications in ophthalmology as they relate to general medical applications. Because lasers were introduced into medicine through ophthalmology in the late 1960's there is much to be learned from the evolution of this exciting technology. Topics to be covered include photocoagulation for diabetic retinopathy and other retinal disorders, glaucoma refractive surgery with lasers, and treatment of ocular tumors.

COURSE DIRECTOR: Mark S. Blumenkranz, MD, Chief Vitreoretinal Surgery, William Beaumont Hospital; Clinical Associate Professor of Ophthalmology, Kresge Eye Institute, Royal Oak

Practical Approach to Common Nephrologic Problems

PRESENTED BY: Department of Internal Medicine, Wayne State University School of Medicine/Harper Hospital

This course through four, thirty-five minute didactic presentations will provide essential physiologic and clinical background as well as guidelines for formulation of an approach to the diag-

nosis and treatment of patients with proteinuria, hematuria and renal calculi. Information will also be presented summarizing the current role of renal transplantation and defining quote "Who is candidate?" clinical problems relating to these topics will be supplied and will be discussed.

COURSE DIRECTOR: Stephen D. Migdal, MD, Associate Professor, Department of Medicine and Co-Director, Department of Nephrology, Wayne State University School of Medicine; Chief, Nephrology, Harper Hospital, Detroit

The Suicidal Patient and the Primary Care Physician

PRESENTED BY: Michigan Psychoanalytic Society

This course will examine the role of the primary care physician in the evaluation and management of suicidal patients and their families. We will look into those factors that interfere with adequate recognition, diagnosis and evaluation of suicidal patients as well as into the various myths that abound concerning such patients. Discussion will be initiated concerning what steps the physicians can take to begin dealing with the suicidal patient. An overview will be given of the impact of suicide on the surviving family members.

COURSE DIRECTOR: Harvey H. Falit, MD, Faculty, Department of Psychiatry, University of Michigan Medical School; Michigan Psychoanalytic Society

Thursday afternoon, November 10



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Advances in Diagnosis and Treatment of Urinary Incontinence

PRESENTED BY: Michigan Urological Society

This course, aimed at all primary physicians, will update the most recent concepts related to the etiology, diagnosis, and treatment of urinary incontinence. Practical 30-45 minute lectures will summarize current knowledge about urinary incontinence in children, males, females, and the geriatric group. Information about related problems such as infection, interstitial cystitis, and success of medical and surgical management will be covered. Adequate time for questions from the audience to the panel will be included.

COURSE DIRECTOR: L. Paul Sonda, III, MD, Associate Professor, Department of Surgery, University of Michigan Medical School

Clinical Correlation of Plastic Surgical Research

PRESENTED BY: Michigan Academy of Plastic Surgeons and Department of Plastic and Reconstructive Surgery, University of Michigan Medical School

This course will introduce ongoing research projects at University of Michigan with clinical application through a series of half-hour presentations. Problems in head and neck reconstruction, osteomyelitis, burns and spider bites will be addressed. Dr. Zuker from Toronto will discuss the treatment of conjoined twins. The evolution of synthetic skin substitutes with their current status will be brought up-to-date.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Division Head, Division of Plastic Surgery, Henry Ford Hospital, Detroit

Financing Long-Term Care: Impact on Patients and Providers

PRESENTED BY: Department of Community Health Science, Michigan State University College of Human Medicine and MSMS Committee on Aging

The aim of this program is to examine national and State of Michigan responses to meeting the long-term care needs of older citizens. Attention will be given to current and proposed mechanisms for financing long-term care services. Several panels will address some of the basic issues regarding the financing of long-term care. Members of panels include representatives of the U.S. Congress, Michigan Legislature, State

agencies, specialists in long-term care, and health care providers.

COURSE CO-DIRECTORS: James G. O'Brien, MD, Professor, Department of Family Practice, Michigan State University College of Human Medicine and Joseph Papsidero, PhD, MPH, Community Health Science, Michigan State University College of Human Medicine

Lasers: Today's Medical Tools (Part II)

PRESENTED BY: Laser Center, Henry Ford Hospital, Detroit

This course, second of a two-part session on the use of lasers in medicine today, will focus on three areas of laser surgery. The first will be gynecological applications, such as the use of the carbon dioxide laser for vaginal and cervical benign and malignant lesions, intraperitoneal use of the CO2 laser for such disorders as endometriosis and tissue welding of the fallopian tubes and the YAG laser within the fundus of the uterus for endometrial abnormalities. The second section will present laser applications for the management of airway abnormalities, focusing on the YAG laser for benign and malignant lesions of the lower airways and the use of photosensitizing agents with a krypton and tuneable dial laser for the diagnosis and treatment of malignancies. The last section will be a presentation of current laser technology in the management of coronary artery disease, with a look to the future. The course will be of interest to primary care physicians as well as specialists. The morning (Part I) session on lasers will cover ophthalmology, ENT and neurosurgery.

COURSE DIRECTOR: Paul A. Kvale, MD, Director, Laser Center and Head, Division of Pulmonary and Critical Care Medicine, Henry Ford Hospital, Detroit; Clinical Professor of Medicine, University of Michigan Medical School

Motility and Other Functional Disorders of the Gastrointestinal Tract

PRESENTED BY: Division of Gastroenterology, Michigan State University College of Human Medicine

This course, aimed at the generalist and consultant, will address some common gastrointestinal problems in which recent advances have significant implications for diagnosis and treatment. Non-cardiac chest pain, non-ulcer dyspepsia, chronic abdominal pain, severe constipation and defecatory disorders will be reviewed. Brief presentations will cover the specific topics, emphasizing clinical application. During the last hour, a panel of the speakers will address questions and involve the audience in problem-solving cases.

COURSE DIRECTOR: David S. Greenbaum, MD, Professor, Division of Gastroenterology, Department of Medicine, Michigan State University College of Human Medicine

New Frontiers in Nuclear Medicine

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

This course, through one-hour lectures, will emphasize the role of the new brain, heart, and endocrine imaging agents in detecting vascular ischemia, Alzheimer's disease, epileptic foci, and adrenal and parathyroid tumors. In addition, osteoporosis and methods for quantification of bone mineral density will be highlighted. The use of dipyridamole as an alternative to exercise-induced stress in detecting coronary artery

disease will also be discussed. The information provided should prove useful in the daily care of your patients.

COURSE DIRECTOR: Darlene Fink-Bennett, MD, William Beaumont Hospital, Royal Oak

Optimal Approach to the Thyroid Patient

PRESENTED BY: Michigan Thyroid Association

This course provides the attendee with detailed information on: 1) Evaluation of the thyroid nodule, 2) Analyzing the results of thyroid hormone tests, 3) Use and abuse of radioiodine therapy of thyroid disease at course conclusion. The attendee should be able to properly diagnose and manage the majority of thyroid problems.

COURSE DIRECTOR: John E. Freitas, MD, Staff Physician, William Beaumont Hospital, Royal Oak

Pediatric Emergencies

PRESENTED BY: Children's Hospital of Michigan

This course will enable physicians to identify symptomatology associated with several pediatric emergencies and provide acute management of specific disease entities. It will also enable the physician to assess and evaluate pediatric patients with head trauma and an altered sensorium.

COURSE DIRECTOR: Alan B. Gruskin, MD, Professor and Chairperson, Department of Pediatrics, Wayne State University School of Medicine and Children's Hospital of Michigan, Detroit

Sports Medicine for Primary Care Physicians

PRESENTED BY: Michigan Academy of Physical Medicine and Rehabilitation

This course is intended for all physicians with an interest in sports medicine. Participants in this course, a combination of lectures and panel discussions, will learn general principles of sports medicine. In addition, they will review diagnosis and management of sports injuries to the upper and lower extremities, peripheral nerve and overuse injuries. The newest concepts in evaluation, treatment and rehabilitation of these sports injuries will be discussed. Time will be available for questions and discussion.

COURSE DIRECTOR: Owen Z. Perlman, MD, Director, Department of Physical Medicine and Rehabilitation, St. Joseph Mercy Hospital, Ann Arbor

Update In Colorectal Surgery

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

This course, through short presentations, and ample time for panel discussions, will provide the participant with the means to recognize serious diverticulitis, treat disabling constipation and learn when radiation is essential in the management of rectal cancer. It also will provide the surgeon with the newest modality in diagnosis and surgery for rectal prolapse.

COURSE DIRECTOR: Omar Kadro, MD, President, Michigan Society of Colon and Rectal Surgeons, Royal Oak

Plan to Visit These Firms' Exhibits



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
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Hyatt Regency, Dearborn

There are 70 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting November 8-10 at the Hyatt Regency Dearborn.

The trained professional representatives of 70 firms will be there to discuss the details of their products and services in a relaxed atmosphere.

The exhibit hall is an important part of the ASM and is the site of registration for all courses and special events. In addition, the deli luncheons and refreshments during breaks are all set up in the exhibit area.

To help you plan, exhibitions are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

■ PHARMACEUTICALS

- 207 Boehringer Ingelheim Pharmaceuticals, Inc.
- 201 DuPont Pharmaceuticals
- 223 Glaxo, Inc.
- 109 Janssen Pharmaceuticals
- 305 Mead Johnson Laboratories
- 219 Mead Johnson Nutritional Division
- 504 Merck Sharp & Dohme
- 308 Parke-Davis
- 505 Reed & Carnrick
- 218 Roche Labs
- 209 Sandoz Consumer Health Care
- 301 Smith Kline & French Laboratories
- 106 E.R. Squibb & Sons
- 501 Syntex Laboratories, Inc.
- 412 The Upjohn Company
- 410 Wyeth-Ayerst Laboratories

■ CLINICAL LABORATORIES

- 204 Advance Medical/Met Path
- 313 CBC Laboratory Service, Inc.
- 110 Health Care Clinical Laboratory
- 215 National Health Laboratories, Inc.
- 310 Oakland Diagnostic Laboratory
- 304 Perry Health Net

■ IN-OFFICE EQUIPMENT AND SUPPORT

- 114 Bell Atlantic Tri-Con
- 206 Brentwood Instruments
- 405 Cellular One
- 108 Firestone X-Ray Corporation
- 103 I.C. Systems
- 102 Medical Staff Placement
- 402 Mobiltronics

■ PATIENT HOME CARE

- 503 Better Health Products
- 217 Caremark Homecare
- 407 Gerber Products Company
- 413 Medical Home Care Pharmacy
- 112 Metro Rehabilitation Services, Inc.

■ COMPUTERS/COMPUTER SERVICES

- 211 Bennethum Computer Systems
- 210 Bennethum Computer Systems
- 411 Colonial Valley Software, Inc.

- 303 Contel Business Systems
- 111 Diversitec-Automated Input
- 222 Diversitec
- 311 MAI Basic Four
- 203 Management Systems Engineering, Inc.
- 101 Medical Billing Service
- 306 Phoenix Management Group
- 404 Professional On-Line Computer, Inc.
- 208 Professional Practice Sales, Inc.
- 302 Scientific Data Management, Inc.

■ EDUCATIONAL RESOURCES

- 408 Encyclopaedia Britannica USA
- 403 J.B. Lippincott Company
- 307 W.B. Saunders

■ PROTECTION

- 107 Blue Cross and Blue Shield of Michigan
- 113 Comerica, Incorporated
- 406 Disability Determination Service
- 205 MPMLC/SCMS (Physicians Liability Insurance/Related Products)
- 409 Michigan National Bank
- 104 Physicians Insurance Company of Michigan
- 115 Physician Service Group, Inc.
- 414 Professional Asset Management, Inc.
- 221 Retirement Plan Consulting Group
- 309 Thomson-McKinnon Securities

■ CAREER

- 220 Henry Ford Westside Medical Centers
- 202 U.S. Air Force Recruiting Service
- 216 U.S. Army Health Professional Support Agency
- 312 W.A. Foote Memorial Hospital, Inc.

■ OTHER EXHIBITORS

- 105 Havenwyck Hospital
- 224 Henry Ford Hospital
- 502 The Oxford Institute
- 212 University of Michigan Medical Center M-Labs
- 213 University of Michigan Medical Center M-Line
- 214 Michigan Chapter of the American College of Nurse-Midwives

Great Lakes Exhibit Center

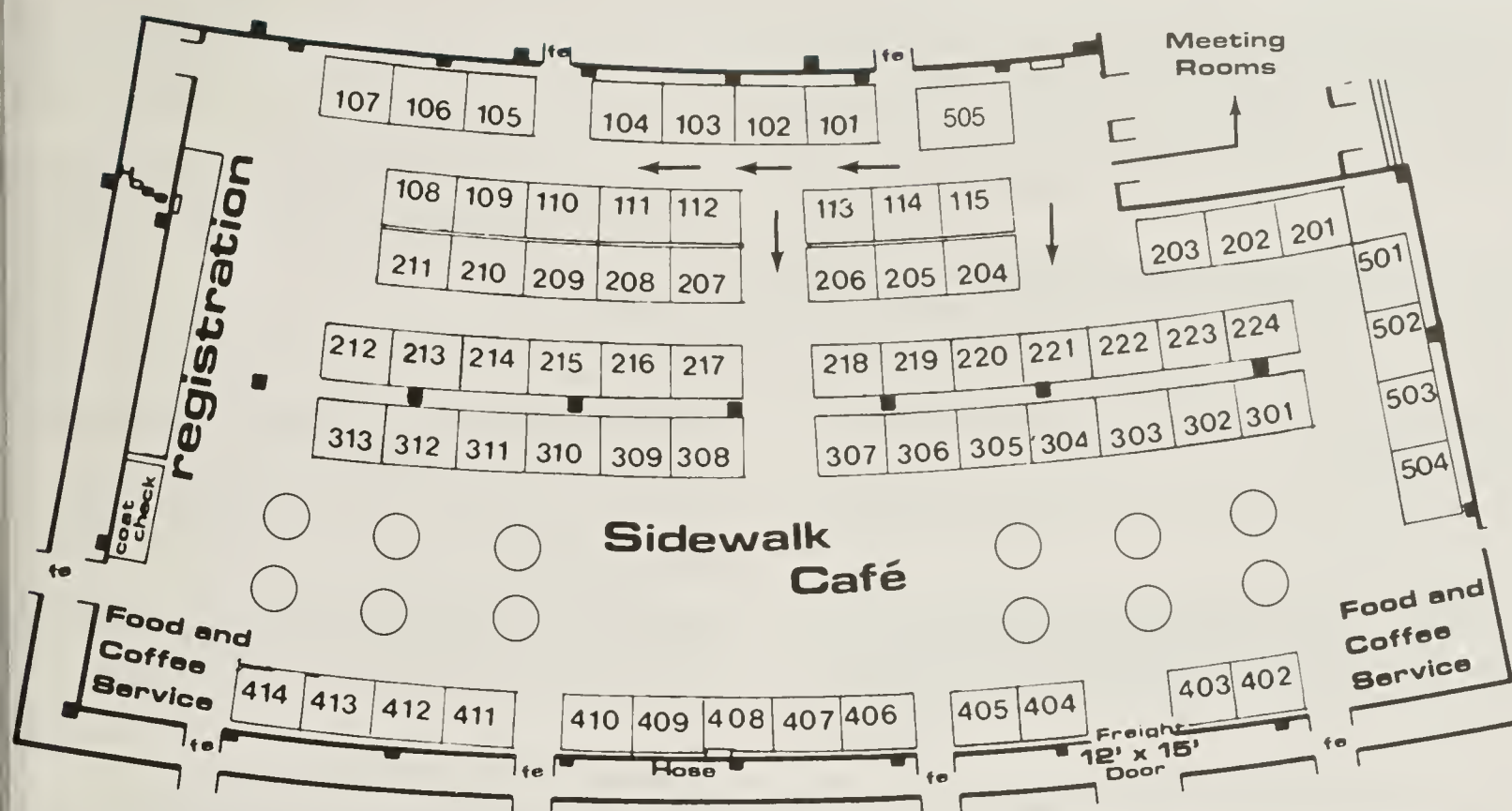


Exhibit Information



**1988 MSMS ANNUAL
SCIENTIFIC MEETING**
November 8, 9, & 10
Hyatt Regency, Dearborn

Exhibit Hours:

Tuesday
Wednesday
Thursday

9:00 a.m. - 6:00 p.m.
9:00 a.m. - 6:00 p.m.
9:00 a.m. - 5:00 p.m.

Coffee:

Tuesday
Wednesday
Thursday

7:30 a.m. - 4:30 p.m.
7:30 a.m. - 4:30 p.m.
7:30 a.m. - 4:00 p.m.

Poster Presentations:

Tuesday
Wednesday

8:30 a.m. - 5:30 p.m.
8:30 a.m. - 5:30 p.m.

Receptions

Tuesday
Wednesday

4:30 p.m. - 6:00 p.m.
4:30 p.m. - 6:00 p.m.

Deli Lunch:

All Three Days

11:45 a.m. - 1:30 p.m.



Clinical Poster Presentations

Tuesday and Wednesday

November 8 & 9

8:30 a.m. to 5:30 p.m.

Main Corridor, Regency Ballroom

Poster displays will be set up beginning at 8:30 a.m., November 8 and 9. Authors will be available to discuss their posters during all refreshment and luncheon breaks both days.

ASSESSMENT OF PULMONARY ASPIRATION WITH SCINTIGRAPHY

Jaroslav Muz, MD; Robert H. Mathog, MD; Lawrence P. Davis, MD and George A. Kling, MD, Wayne State University School of Medicine

CRITICAL CLINICAL ASSESSMENT OF SAFETY OF OFLOXACIN AND ENOXACIN IN AN AMBULATORY SETTING WITH SPECIAL REFERENCE TO CNS TOXICITY

Tom Madhavan, MD, FACP and Denise Cunningham, RN, Providence Hospital

DIAGNOSTIC VALUE OF ROUTINE CHEST RADIOGRAPHS IN PATIENTS HOSPITALIZED WITH EXACERBATIONS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Joseph A. Skoney, MD; Stanley Sherman, MD, FACP, William Beaumont Hospital, Royal Oak

DIFFICULT AIRWAY CLINIC Martin L. Norton, MD, JD; Allan C. D. Brown, MB, ChB, FFARCS; Niall Wilton, MRCP, FFARCS; Robert B. Powell, CRNA, MN, University of Michigan Medical Center

ESOPHAGEAL FUNCTION STUDIES (EFS) AND THE DILEMMA OF CHEST PAIN

Jian Chen, MD; Rajyasree Emmadi, MD and Yvan J. Silva, MD, Wayne State University School of Medicine

EVALUATION OF A SIMPLIFIED METHOD OF CRYOPRESERVING HUMAN PARATHYROID TISSUE FOR AUTO-TRANSPLANTATION

Andrew Saxe, MD; Selwyn Kay, MD; Glenn Gibson, BS; Sinai Hospital of Detroit

MENINGOCOCCEMIA, MENINGITIS AND PERSISTENT FEVERS IN AN ELDERLY MAN

S. Sattar, MD, S. Zaidi, MD, F. Garcia, MD, E. Habte-Gabr, MD and R. Rosenbaum, MD, Hurley Medical Center

MULTIPLE INTRACRANIAL PATHOLOGIES

Mohammad Shakfeh, MD and Omar Bakr, MD, Hurley Medical Center

OUTPATIENT PARENTERAL ANTIBIOTIC THERAPY: A COST EFFECTIVE ALTERNATIVE TO CONTINUED HOSPITALIZATION

Tom Madhavan, MD, FACP, Providence Hospital

OVERUSE AND MISUSE OF ARTERIAL BLOOD GASES: THE ROLE OF PULSE OXIMETRY

Gerald Godfrey, MD; Stanley Sherman, MD, FACP; Renee Faner, RRT; K.P. Ravikrishnan, MD, FACP, William Beaumont Hospital, Royal Oak

PREVALENCE OF ACUTE INTERMITTENT PORPHYRIA IN A COMMUNITY HOSPITAL

Joseph V. Heflin, MD; James Piper, MD; Martha Kreimer-Birnbaum, PhD, and David Pieper, PhD, Providence Hospital

PULMONARY ARTERIOVENOUS MALFORMATIONS DIAGNOSED BY DIGITAL SUBTRACTION ANGIOGRAPHY (DSA)

Tammy Chiesa, MD; Alan D. Jacknow, MD; Stanley Sherman, MD, FACP; K.P. Ravikrishnan, MD, FACP, William Beaumont Hospital, Royal Oak

RENAL ARTERY EMBOLISM

S. Sarvaria, MD, A. Baloch, MD and R. Rosenbaum, MD, Hurley Medical Center

ROLE OF SLOW CONTINUOUS ULTRA-FILTRATION (SCUF)/CONTINUOUS ARTERIO-VEIN HEMOFILTRATION (CAVH) IN THE MANAGEMENT OF ICU PATIENTS

S. Sanchez, MD; R. Jimenez, MD; N. Salem, MD; W. Meyer, MD; V. Kinni, MD; J. Rick, MD, Providence Hospital

TOPICAL TRETINOIN IMPROVES PHOTOAGING

Charles N. Ellis, MD; Johathan S. Weiss, MD; John J. Voorhees, MD, University of Michigan Medical School

TOWARD DEFINING AN OVERALL FETAL ALCOHOL DOSE-RESPONSE RELATIONSHIP IN HUMAN PREGNANCY

R.J. Sokol, MD; J.W. Ager; S. Martier, Hutzell Hospital and M. Morrow-Tlucak; C.B. Ernhart, Case Western Reserve University Metro General Hospital, Cleveland, Ohio

UNUSUAL CAUSES OF COMPLETE HEART BLOCK

Heidi K. Lang, DO; Tamara L. Holt, DO; Wolf F. C. Duvernoy, MD, FACP; Jeffrey M. Zaks, MD, FACP, Providence Hospital

UPPER EXTREMITY AND SUPERIOR VENA CAVAL RADIONUCLIDE VENOGRAPHY: A NEW IMAGING PROTOCOL

E.C. Schane, MD and C.E. Nagle, MD, William Beaumont Hospital, Troy

Restaurants

Average cost per meal

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\$\$\$ Over 15 dollars

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A full range of dining options are available without ever leaving the Hyatt.

Kafay's Place

If you're looking for something on the lighter side try Kafay's Place, featuring soups, salads and sandwiches all day long. For dinner the menu expands to include Mexican specialties. Open from 6:30 a.m. until midnight. \$

Giulio and Sons

The market atmosphere of Giulio and Sons features Italian-American dishes including veal and chicken specialties. There is also a large salad bar with homemade pasta and a wide variety of meats. Lunch is served daily from 11:00 a.m. until 2:30 p.m. and dinner is from 6:00 p.m. until 10:30 p.m. \$\$\$

The Sushiiwa Hyatt

For something a little more adventuresome the Sushiiwa Hyatt is a good place to start. Authentic Japanese fare is their forte. Shabu-shabu (Japanese beef fondue) heads up the list of traditional favorites and for the dedicated aficionado of Japanese food there is a sushi bar. Open for lunch 11:00 a.m. to 2:30 p.m. and dinner 6:00 p.m. to 10:30 p.m. \$\$

The La Rotisserie

More formal dining can be found at the La Rotisserie. Fresh cut flowers, china and candlelight create a luxurious atmosphere for an evening meal. The dining room opens at 6:00 p.m. The La Rotisserie features a full continental menu. \$\$\$

Eating "out" in the Dearborn area.

If you need to get out after a long day of CME you might consider trying one of the Dearborn area's fine or unusual restaurants.

Fairlane Charley's

700 Town Center Drive
336-8550

For those who don't want to wander far from the ASM, Fairlane Charley's is only a few steps away in the Fairlane Town Center. Charley's is open for lunch 11:00 a.m. to 4:00 p.m. with soups, salads and sandwiches. Dinner, served 6:00 p.m. until 10:30 a.m., features a fresh seafood catch, beef and chicken entrees. \$\$

The American Bar and Grille

17000 Hubbard Drive
271-4020

The American Bar and Grille features regional American atmosphere and food. The American Bar specializes in grilled seafood, chicken and beef. A wide variety of sandwiches are also available. Open weekdays 11:00 a.m. until midnight. \$\$



1988 MSMS ANNUAL
SCIENTIFIC MEETING
November 8, 9, & 10
Hyatt Regency, Dearborn

The people mover which formerly provided transportation from the Hyatt to the Fairlane Towne Center will not be in service for the duration of the Annual Scientific Meeting.

The Peacock Restaurant

4045 Maple
582-2344

The Peacock Restaurant is a good stop for the truly unusual. Cuisine direct from India is the fare. The Peacock is proud of its curries and vegetable dishes. Delicious breads like papadams, chapatis and pooris (deep fried puff balls) are also a specialty. Dining hours are 11:00 a.m. until 2:30 p.m. for lunch and 5:30 p.m. until 10:30 p.m. for dinner. \$\$

The Chambertin

22900 Michigan Avenue
278-4800

More elegant dining may be found nearby at the Chambertin, located in the Dearborn Holiday Inn. The Chambertin features beef and lamb entrees. The tavern is open from 11:00 a.m. until 2:00 p.m. for lunch and dinner is served from 5:00 p.m. until 9:00 p.m. \$\$\$

Silky Sullivan's/Kiernan's Steak House

21931 Michigan Avenue
565-4260

An unusual mix of elegant and casual cuisine can be found at these adjoining restaurants, especially at Silky's. Open 11:00 a.m. to 2:00 a.m., the steakhouse offers less expensive fare. \$\$

The Beirut Gardens

13944 Michigan Avenue
581-9697

An excellent spot for people with larger appetites, the Beirut Gardens features oversized portions of shish-kabob, baba ghanoush and other Arab specialties. This family owned diner is open from 11:00 a.m. to 10:00 p.m. \$

Don Carlos/La Casa de Speedy Burrito

13701 W. Warren
582-2024

Fifteen different kinds of burritos are the hallmark of the Speedy Burrito. Almost anything you would like, from lamb to potatoes can be stuffed into one of Don's speedy burritos. Other Mexican standbys are available, such as menudo or tripe soup. Open 11:00 a.m. to 9:00 p.m. \$

Charley's Crab

5498 Crooks Road, Troy, Michigan
879-2060

A short drive will get you to Charley's Crab, one of the area's most unique restaurants. Fresh fish and seafood specialties are served to you in a dining room which was once the living room of Packard Motor Company Executive Alvin Macaulay or in the Farragut Room which is adorned with artifacts from one of America's last square rigged whaling ships. Charley's Crab also offers a raw bar large enough to accommodate 80 people. Lunch is served from 11:30 a.m. until 4:00 p.m. and dinner is from 5:00 p.m. until 11:00 p.m. The raw bar opens at 4:00 p.m. and closes at midnight. \$\$\$



Whether you are looking for a leisurely walk through chrysanthemums or a night of musical swashbuckling on the high seas, Detroit has something just for you.

November 8th:

"I'm Not Rappaport"

November 8,9 & 10 Birmingham theater.

A comedy of two unforgettable characters set together on a bench in Central Park. For showtimes and reservations contact the box office at 644-3533.

"A Comedy of Errors"

November 8,9 & 10 Meadowbrook theater.

Shakespeare at its best. All seats are \$15.00. Showtime is 8:00 p.m. For reservations contact the box office at 377-3300.

Windsor Symphony Society

November 8 Windsor Art Gallery.

The symphony will be presenting a show entitled "Mostly Mozart." All seats are \$12.50. Showtime is 8:00 p.m. For reservations contact the box office at (519) 252-6579.

Detroit Institute of Art

November 8,9 & 10

The institute will be featuring a gallery of *Newsweek* photographs and a special collection of over 100 sixteenth century Tuscan drawings. Admission is free of charge. Institute hours are 9:30 a.m. until 5:30 p.m.

Belle Isle Conservatory

November 8,9 & 10

The conservatory will be exhibiting its brand new chrysanthemums. Admission is free of charge. Conservatory hours are 9:00 a.m. until dark (roughly 6:00 p.m.)

November 9th

The Detroit Symphony Orchestra

November 9

The Detroit Symphony will be presenting the "Brahms Festival" at Ford Auditorium. Seats are available for \$15.00, \$25.00, \$35.00 and \$75.00 (\$75.00 seats include a suite table and champagne) Showtime is 8:00 p.m. For reservations call 567-9000.

"Life in the Theater"

November 9 Wayne State University's Hillberry Theater.

A contemporary drama. Seats are \$8.00 and \$10.00. Showtime is a 2 p.m. matinee. For reservations contact the box office at 577-2972.

November 10th

The Vienna Symphony Orchestra

November 10 Orchestra Hall of Detroit.

Seats are \$15.00, \$20.00, \$25.00 and \$30.00. Showtime is 8:00 p.m. For reservations contact the box office at 833-3700.

"Gone to Glory"

November 10 Detroit Repertory Theater.

A satirical comedy of two sisters tucked away in a forest home owned by a divorcee. All seats are \$10.00. Showtime is 8:30 p.m. For reservations contact the box office at 868-1347.

November 11th

"The Pirates of Penzance"

November 11 Fisher Theater.

Seats are \$10.00, \$18.00, \$25.00, \$35.00 and \$40.00. Showtime is 8:00 p.m. For reservations contact the box office at 874-7464.

"Golden Dawn"

November 11 Detroit Center for Performing Arts.

A contemporary drama. All seats are \$10.00. Showtime is 8:00 p.m. For reservations contact the box office at 961-7925.

"Laura"

November 11 Henry Ford Dinner Theater.

A suspense filled murder mystery. All seats are \$7.00 for the performance only and \$21.25 for dinner and the show. Dinner is served at 7:00 p.m. For reservations contact the box office at 271-1620.



Registration Form

for Category I CME Courses

Name _____
(first) (initial) (last)
Address _____
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County _____ Phone () _____
MSMS Member: Yes ☐ No ☐ Resident ☐ Specialty _____ Other _____

Physicians must make their own hotel reservations prior to 10/13/88 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

CHOOSING YOUR COURSES

Please check the courses you wish to attend. In each case, **please indicate a second choice** should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

TUESDAY MORNING, NOVEMBER 8 (8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ A Practical Approach to Hyperlipidemia
- ☐ Acute Coronary Syndromes: Mechanical & Medical Interventions
- ☐ Arthritis in the Office
- ☐ Basic Cardiac Life Support
- ☐ Current Concepts in Gynecological and Obstetrical Pathology
- ☐ Hypertension — Current Therapeutic Update
- ☐ Perioperative Problems for the Primary Care Physician
- ☐ Venous Disorders: Current Management
- ☐ Wiping Out Sinus Disease

WEDNESDAY MORNING, NOVEMBER 9 (7:15-8:15 AM)

_____ "Early Bird" Plenary Session on AIDS
(continental breakfast included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ A Practicum on Arterial Blood Gases
- ☐ Acute Visual Problems
- ☐ Basic Cardiac Life Support
- ☐ Cancer Prevention and Detection for Primary Care Physicians
- ☐ Current Status of Drug Testing
- ☐ Diagnostic Ultrasound in Modern Medicine
- ☐ Estrogen Replacement Therapy
- ☐ Planning For Pregnancy in Diabetes Mellitus
- ☐ The Handicapped Patient in Society and Private Practice

THURSDAY MORNING, NOVEMBER 10 (8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Animation of the Paralyzed Face
- ☐ Basic Cardiac Life Support
- ☐ Cardiovascular Disease in Women: The Pill, and Estrogen Replacement
- ☐ Current Concepts in Sleep Apnea
- ☐ Gastrointestinal Endoscopy and the Generalist
- ☐ Lasers: Today's Medical Tools (Part I)
- ☐ Practical Approach to Common Nephrologic Problems
- ☐ The Suicidal Patient and the Primary Care Physician

Lunch sandwich will be provided at no extra charge for paid registrants. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

Tuesday lunch ☐

Wednesday lunch ☐

Thursday lunch ☐

TUESDAY AFTERNOON, NOVEMBER 8 (1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Children with Chronic Illness: Shared Needs and Concerns
- ☐ Clinical Neuroradiologic Applications of Magnetic Resonance Imaging
- ☐ Clinical Toxicology for the Front Line Physician
- ☐ Common Problems in Hematology
- ☐ Family Counseling Skills for Office Practice
- ☐ Neuromuscular Diseases
- ☐ Physicians Recovery Network: Help a Friend
- ☐ Pulmonary Infections
- ☐ Rehabilitation of the Elderly: Keeping Older Patients on Their Feet

WEDNESDAY AFTERNOON, NOVEMBER 9 (1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ AIDS Update
- ☐ Allergy and Asthma Update
- ☐ Back Pain: Returning to Work
- ☐ Common Office Pediatric Problems
- ☐ Common Otolaryngologic Problems in Children
- ☐ Current Controversies in Anesthesiology
- ☐ Dermatology Update in '88
- ☐ Radiology for Clinicians
- ☐ The Physician's Office Laboratory in 1988
- ☐ Violence in the Family

THURSDAY AFTERNOON, NOVEMBER 10 (1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Advances in Diagnosis and Treatment of Urinary Incontinence
- ☐ Clinical Correlation of Plastic Surgical Research
- ☐ Financing Long-Term Care: Impact on Patients and Providers
- ☐ Lasers: Today's Medical Tools (Part II)
- ☐ Motility and Other Functional Disorders of the Gastrointestinal Tract
- ☐ New Frontiers in Nuclear Medicine
- ☐ Optimal Approach to the Thyroid Patient
- ☐ Pediatric Emergencies
- ☐ Sports Medicine for Primary Care Physicians
- ☐ Update in Colorectal Surgery

YOUR PAYMENT

MSMS Members: \$25 for each half-day course

MSMS Members with "retired status" pay half

Non-members: \$50 for each half-day course

Residents: \$15 for each half-day course

Students: NO CHARGE — Limited Enrollment

Lunch tickets may be purchased)

Multiply total number of half-day courses by appropriate fee:

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_____ x \$12 (retired) = \$_____

_____ x \$50 (non-members) = \$_____

_____ x \$15 (residents) = \$_____

_____ x \$0 (students) = \$_____

_____ x \$10 (student lunch) = \$_____

TOTAL = \$_____

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Send this entire page with your check.

Confirmation of your reservation will be sent to you.

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 19 credit hours in Category I toward the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed. This program has been reviewed and is acceptable for a maximum of 19 Prescribed hours by the American Academy of Family Physicians.



**1988 MSMS ANNUAL
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Hyatt Regency, Dearborn

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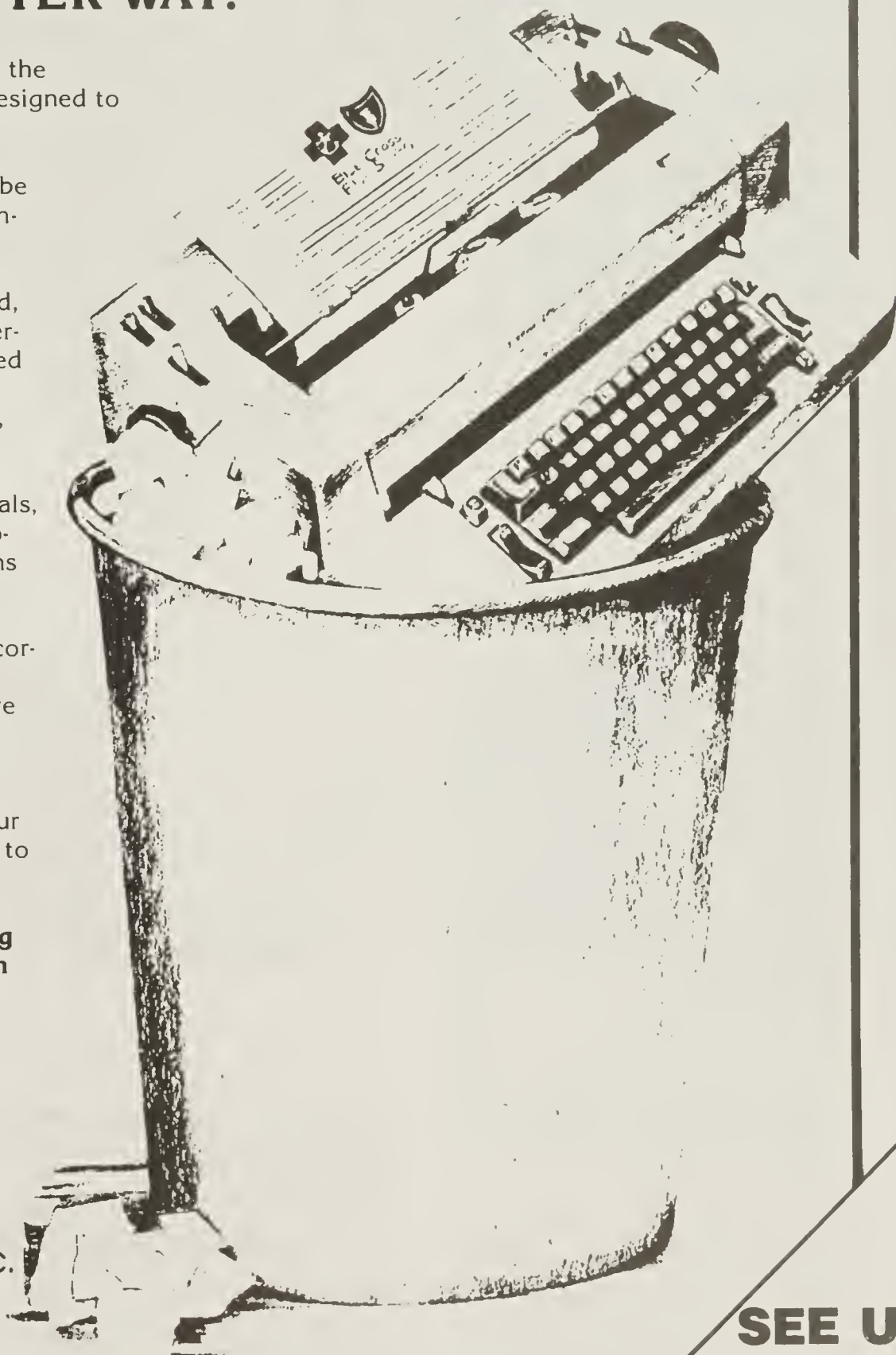
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The life of Joan Stryker, MD: A long line of firsts

By Judy Marr, Editor

“We had a big retirement party for her recently, but nothing has changed!” observed the nurse scheduling Joan C. Stryker, MD, in her appointments at the Mott Clinic, Detroit.

The status quo probably shouldn't have surprised the nurse of the indomitable 70-year-old gynecologist. Doctor Stryker, who has one of the most dynamic careers of any Michigan physician, seems to have no intention of retiring.

She is chairman of the 1988 and 1989 MSMS Annual Scientific Meetings, and directs the innovative Wayne State University School of Medicine's Menopausal Clinic, which she founded. A WSU professor emeritus, she is co-chairman of the medical student's ob/gyn rotation, and also works with residents.

Doctor Stryker is the 1988 recipient of the WSU School of Medicine's Distinguished Service Award, which cited her for “a long line of firsts throughout her distinguished career.”

She has devoted her efforts to women's health issues, with a special interest in problems affecting the socially- and economically-disadvantaged. She has paved new ground, often in the face of controversy, in such areas as adolescent pregnancy, drug addiction and menopause.

“I don't think my life has been any more unusual than any others,” Doctor Stryker observes. Few would agree with her, for



Doctor Stryker

her achievements put her on a plane well above the ordinary.

These include first woman ob/gyn resident at the University of Michigan, founder of the Detroit area's first comprehensive contraception clinic for indigent women, of the first clinic for pregnant addicts — one of only three in the country, and of the first clinic for pregnant adolescents in Detroit.

She is a founding fellow of the American College of Obstetricians and Gynecologists, and was the first woman to be elected president of the state chapter. She is a member of the Michigan Cancer Society Board of Directors, and recently was selected to the Alpha Omega Alpha Honor Medical Society.

Doctor Stryker is the mother of a daughter and two sons, one of whom, David, is an internal medicine subspecialist in Albuquerque. She took up scuba diving three years ago, to further her hobby of underwater photography. She is an accomplished

vocalist and outdoors enthusiast.

“My family instilled in me to be adventurous, to try and not be afraid,” she says. “There still are thousands of things left to do!”

She was juggling career and family responsibilities well before the great movement of women into the workplace.

“Organization is the main thing — giving everybody their responsibilities,” she advises. “You also have to realize that you carry your weight, and maybe a little more.”

She took time to be with her children as they were growing. “When they were in high school, active in sports, I was the team physician!”

She recalls very little problem with being a woman in a male-dominated profession.

“You have to realize you are a woman first, and a lady, and act like one,” she says. “On the occasions I found someone I had difficulties with, I let him know I could be as aggressive as he.”

MSMS is fortunate to have this esteemed professional woman to lead its meeting planning efforts for the next two years. And she has strong ideas about how to accomplish this latest in her many leadership roles.

“The most important thing that we need to obtain for the Scientific Meeting,” she says, “is relevant, factual, scientifically-sound and current information.

“We trust, at this meeting, we have covered a broad sweep of topics.” □



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Could another insurance crisis be brewing?

By Thomas R. Berglund, MD

Michigan's health care delivery system was in critical condition when the medical liability insurance crisis erupted in the mid-1970s.

The crisis was inflamed by wildly escalating malpractice claims and fanned by briskly declining stock market investment earnings.

It erupted when commercial insurers couldn't or wouldn't take the heat. They abandoned the marketplace and their policyholders.

Crisis was upon us. It affected physicians, but also threatened the stability and availability of medical care.

A revisiting of these historic events is important. Some physicians have forgotten or ignored elements of the crisis.

Now, after nearly 15 years, commercial insurers are returning to the Michigan marketplace, along with new insurance entities.

They're luring physicians with lower premiums (at least initially). The stage could be set for another crisis.

Most of us who experienced the mid-70s crisis know there is no guarantee that commercial insurers will stay here when the liability climate deteriorates, or when profits dip.

Low first-year, claims-make premiums may look good now, but what about the so-called "mature" rate and cost of "tail"

Doctor Berglund is president and chairman of MPMLC.



MPMLC's board members, seated from left: Robert M. Leitch, MD, President Emeritus (Battle Creek); Thomas R. Berglund, MD, President and Chairman (Portage); Ernest P. Griffin, Jr., MD (Grand Blanc); Thomas C. Payne, MD (East Lansing). Standing, from left: Kenneth J. Ray, MD (Grosse Ile); Jay K. Harness, MD (Ann Arbor); Louis E. Heideman, MD (Detroit); Dale L. Kessler, MD (Grand Rapids); Myron R. Emerick, DO (Mt. Clemens). Two new board members (not pictured) are Billy Ben Baumann, MD (Pontiac), and John W. Hall, MD (Petoskey).

coverage if the policy is discontinued or the company stops doing business here? (More about this in the section entitled "A New Challenge.")

The Michigan State Medical Society has had professional liability at or near the top of its list of key issues since 1974 when the crisis flared.

Crisis factors

Several issues emerged, then merged, in the mid-70s:

- Liability insurance premiums were artificially low. Insurers depressed them to encourage new business so that premium dollars could be invested at pre-existing favorable rates of return.
- Stock market investment earnings suddenly tumbled, creating financial difficulties for in-

surers.

- The consumer movement contributed to a new wave of social and economic entitlement concepts; judges and juries became more sympathetic to injured parties and more liberal with insurance company payouts.
- Michigan adopted a no-fault approach to auto accident injuries. That contributed to an increase in medical malpractice and product liability lawsuits.

Major insurers decided it no longer was profitable to stay in Michigan. They withdrew, or priced their coverage beyond practical reach.

Thousands of physicians were left without liability protection; others were reluctant to treat

Continued on page 626

Stranded.



IN THE MID-SEVENTIES, major liability companies stopped providing coverage for Michigan doctors. This left thousands of us stranded with no access to protection. In response, we united to build an insurance company to represent our own interests.

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Telephone: 800-678-2448 or 517-351-1150

BERGLUND/Continued

complex, high risk cases; the era of defensive medicine was under way; the cost and availability of medical services surfaced as concerns, if not problems, for the entire community.

By the end of 1974, only one insurer (out of a potential of 300) was actively writing medical liability coverage here.

Quick action by MSMS

MSMS responded. Top leaders met with the governor (William Milliken), formed several action groups and appointed Frank B. Walker, MD, Detroit, (current MSMS Chairman of the Board), to head an eight member task force to study the feasibility of forming a physician-owned insurer.

Brooker L. Masters, MD, Fremont, MSMS president during that turbulent period, actively campaigned for solutions to the crisis. He and George D. Stilwill, MD, Lansing, were among a cadre of key leaders engaging the issues.

After five months of intensive efforts, the task force recommended formation of a mutual insurance company, owned by policyholders.

At its May, 1975 House of Delegates meeting, MSMS approved the recommendation.

MPMLC is formed

On June 3, 1975, 21 physicians

met at MSMS headquarters to incorporate Michigan Physicians Mutual Liability Company (MPMLC). Doctor Walker chaired the historic event.

Current MSMS Executive Director William Madigan played a key role. At the time, he was a consultant to MSMS. His first project was to market the new company.

MPMLC's first board of directors was named (all medical doctors who had taken part in planning and discussion sessions): Vernon V. Bass, Saginaw; Ernest P. Griffin, Flint; Louis E. Heideman, Detroit; Dale L. Kessler, Grand Rapids; Robert M. Leitch, Battle Creek; Kenneth J. Ray, Trenton; Robert E. Rice, Greenville; Donald N. Sweeney, Detroit; and Frank B. Walker.

Doctors Griffin, Heideman, Kessler and Ray still serve on MPMLC's all-physician board. Doctor Leitch is "president emeritus" (he retired last May after serving as president and chairman since 1980).

The 21 physicians who incorporated the company named Stratton-Cheeseman & Associates (administrator of MSMS' member insurance benefit plan) to staff and manage it.

In August, SC & A president, William B. Cheeseman, incorporated Stratton-Cheeseman Management Company (SCMC) as a separate entity to serve MPMLC's board, policy holders and the medical community.

MPMLC maintains strong

links with MSMS in carrying out its mission: To have uniquely extensive physician involvement in providing reliable and adequate physicians.

A new challenge

Over the past seven months, commercial companies have returned and new insurance entities have surfaced.

The advent of claims-made coverage for physicians here precipitated this trend. The Michigan Insurance Bureau authorized sale of claims-made to physicians effective January 1, 1987.

Previously, only occurrence coverage was sold.

Early in 1987, MPMLC began advising physicians about the differences between claims-made and occurrence coverage, plus cautioning about the anticipated re-entry of commercial insurers.

A first-year claims-made premium is significantly lower.

That's because the premium finances a first-year incident that results in a first-year claim. Since the risk of that happening is relatively low, so too, is the premium.

Subsequent-year premiums increase along with the risk of claims, and physicians must maintain continuous coverage or lose liability protection (unless they qualify for free "tail" protection or purchase "tail" coverage).

Typically, by the fifth year, the claims-made premium

Continued on page 628

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BERGLUND/Continued

reaches "maturity"—the cost will peak for the basic protection (sufficient to cover past year incidents that surface as current-year claims).

The "mature" rate and the cost of "tail" coverage should be given more attention than the first-year premium.

If physicians, or their insurers, discontinue claims-made coverage, there is no liability protection against claims reported after that time—unless "tail" coverage

is earned or purchased.

That's why it's important for physicians to remember the mid-1970s crisis. Commercial insurers neither have, nor owe, an allegiance to physicians or the medical community.

They could abandon the marketplace and set a prohibitively high price for "tail" coverage.

Unlike a commercial insurer, MPMLC would not consider, let alone implement, such a plan. The company is owned by policyholders and led by an all-physician board of directors.

Unlike boards of directors for commercial insurers, MPMLC's board isn't concentrating on locking in policyholders for ultimate maximum premiums and profits. MPMLC's focus is premium restraint and long-term service to physicians.

Physicians should consider the lessons of the past.

Above all, they should rely on a company with strong ties to MSMS and a commitment to physicians—in favorable times or in crisis. □

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ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

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OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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Contraindication: Known allergy to cephalosporins

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea), 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever), 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other: eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis, elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly)

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"Medically Unnecessary" Treatment - What Every Physician Should Know

By Rose B. Heald
MSMS Chief, Health Care Programs

Physicians throughout Michigan continue to receive letters from Medicare threatening sanctions and civil penalties if refunds to patients for "medically unnecessary" services are not made within 30 days. The letters, which are directed at non-participating physicians only, have angered physicians. They feel the federal government is purporting to tell physicians how to practice medicine and, in the process, eroding the patient's confidence in their doctor. While pressure from MSMS on a local basis and the AMA nationally has alleviated many of the worst complications and further relief is on the way, there are still numerous problems and irritations with the program.

This issue's **Physician's File** will explain how the physician should respond if a claim is denied as "medically unnecessary," the procedure Blue Cross Blue Shield of Michigan (BCBSM) should follow in notifying physicians, and the process for appealing denied claims.

History of the "Medically Unnecessary" Program

The requirement that physicians must make refunds to patients for "medically unnecessary" services is one part of a giant budget reconciliation measure implemented October 1, 1987, as a provision of the Omnibus Budget Reconciliation Act of 1986 (OBRA).

The original provision required non-par physicians, who provided services on an unassigned basis, to pay refunds to patients for services subsequently determined by Medicare to be "medically unnecessary." Physicians who fail to comply are subject to a maximum \$2,000 fine and/or exclusion from the Medicare program.

There are two exceptions to the refund provision:

1. If the physician could not reasonably have known that the service would be denied, or
2. If the patient agreed to pay for the service even after being warned that it might not be covered.

The first exception applied if the service had never been denied in the past, and the second required proof that the patient agreed to pay if Medicare found the service unnecessary.

Physicians' frustration was exacerbated by the failure of the "medically unnecessary" letter to identify what services the patient received that were unnecessary or to describe how the physician should respond. The letters were unsigned, leaving the physician with no indication of whom to contact for further information.

Many of the services denied are automatically "bumped out" by a computer based on HCFA's payment criteria for special review. Ideally, the carriers should then individually review claims and pay them where the physician can justify the service. Both patients and physicians complain, however, that some carriers are automatically denying these claims without looking any further.

To further complicate the situation, patients were receiving letters from the carrier indicating they might be due a

refund at the same time letters were going out to physicians. This meant a physician's patients were getting notice of "unnecessary services" prior to the physician having an opportunity to respond to the allegation.

Additionally, many letters were sent in error for services that Medicare has *never* covered, calling these services "unnecessary" rather than identifying them as uncovered benefits.

How Many Physicians Affected

No one knows, not even HCFA, how many letters have been sent nationwide, but the figure is in the tens of thousands. In Michigan, BCBSM has sent 8,602 letters to physicians between January 1, 1988, and August 8, 1988, averaging about 1,200 letters per month. This includes 868 reduction letters in which BCBSM reduces reimbursement to a less extensive service.

Approximately 1,000 appeals were filed each month from March through July, 1988, although information on the resolution of these appeals is unavailable. We do know, however, that BCBSM has not imposed any fines for noncompliance of the refund provision.

Success in Winning Refund

By February even HCFA agreed that major changes were needed. AMA negotiations won important reforms for physicians.

Effective April 1, the Medicare carrier is required to contact physicians for additional information before a claim is denied on "medically unnecessary" grounds. In addition, Medicare carriers must now distinguish between payment denials for medically unnecessary service and non-covered service. Claims for non-covered services, such as routine physical exams, are not subject to the refund requirement.

HCFA also agreed to an AMA request for revisions in the carrier's refund letters to eliminate language offensive to physicians, identify the service in question, the basis for



denial and to provide a point of contact for appeals and other questions.

Medical Necessity in Michigan

The first contact Michigan physicians should receive from Blue Cross Blue Shield of Michigan (BCBSM), the local carrier, is a "development" letter indicating that a medical review for a Medicare claim is being conducted and requesting additional documentation to substantiate medical necessity. The letter requests the physician provide this information to BCBSM within 45 days.

Claims that exceed BCBSM parameters should include additional documentation, such as physician notes, operative notices, clinical records, procedure reports, etc. HCFA mandates 14 national prepayment review screens and BCBSM administers an additional 34. A complete listing of BCBSM's Medicare Part B Prepayment Utilization Review Screens and Parameters appears in the April edition of the *Record*.

If a claim is still found to be "medically unnecessary" after the additional information is reviewed, the physician

will receive a claim denial notice. This notice should include information on the specific service being denied along with a carrier contact and telephone number. Questions about a denied claim should be referred to the BCBSM Government Provider Inquiry Department at **313/225-8222** or **1-800-482-8760**.

In the event a claim is denied, and the physician chooses not to appeal, the physician is required to refund to the patient any payments collected for that service, including deductible and co-insurance amounts.

This applies both to medical necessity denial of payments as well as to so-called "medical necessity reductions." In the latter situation there is, in effect, a denial of the more extensive service on the basis that it is not reasonable and necessary even though Medicare payment is made for the less extensive service. For example, a comprehensive office visit might be reimbursed as a brief office visit. In the case of a medical necessity reduction, the physician is asked to refund to the patient any amounts collected exceeding the physician's MAAC for the less extensive procedure.

Current HCFA-Mandated Prepayment Screens (As of December 1986)

Screen	Parameter
1. Routine foot care (excludes surgery for acute condition and mycotic nails)	One treatment (HCPCS T1060) every 60 days
2. Injections: joint	Joint injections (HCPCS 20600, 20605, 20610)-3 injections per month
3. Mycotic nails	One treatment (HCPCS 11700, 11701, 11710, 11711) every 60 days
4. Nursing home visits	One per month (HCPCS 90430-90470, M0040, M0045)
5. B-12 injections	One injection (HCPCS J3420) per month, based on diagnosis
6. New patient office visits	Comprehensive physical examinations, one per carrier history period by the same provider (HCPCS 90020)
7. Holter monitoring	No more than one instance (HCPCS 93270-93277) per 6 months
8. Chiropractic	One per month (HCPCS A-2000-A-2999)-chronic condition
9. Concurrent care	Same date of in-hospital service, different practitioner, same or similar specialty (use HCPCS modifier 09975 or -75)
10. Hospital visits	30 per month; 30 per 3 months (HCPCS 90240-90280)
11. Comprehensive office visits	Established patient comprehensive level (HCPCS 90080), 1 visit per 6 months
12. Skilled nursing facility (SNF)	Subsequent care brief service (HCPCS 9045-90370)-2 first week, 1 per week thereafter
13. Injections	All injections excluding B-12, allergy, joint and chemotherapy-24 per year-HCPCS-level one (CPT-4) and level two (alpha numeric) where appropriate
14. Urological supplies	No more than 2 per month (HCPCS A4341-A4346)
15. Replacement of post cataract prosthetic contact lenses	One contact lens replacement per eye per year (HCPCS 66980)
16. Assistants at cataract surgery	Assistant surgeons during cataract surgery (HCPCS 66820-66985) use modifier-80 with appropriate procedure code or use separate 5 digit modifier-09980

Physician's FILE

A refund must be made within 30 days after the day the physician receives the notice requiring the refund or, if the physician appeals the determination, the refund must be made within 15 days after the date the physician receives notice that the appeal was rejected.

Waiver Forms

One exception to the medical necessity refund requirement, as mentioned earlier, is if the patient agrees to pay for a service after he/she has been informed by the physician that Medicare is unlikely to reimburse for that service. The physician must inform the patient in advance of providing the service and retain proof that the patient agreed to make payment in spite of the likelihood that Medicare would deny reimbursement.

The physician may ask the patient to sign a waiver in order to satisfy the above requirement. A waiver must clearly indicate that the physician has some doubt regarding the likelihood of Medicare payment and state the reasons why. General statements and routine notices given to all patients are inadequate.

The statement below, which appeared in the August *Record*, meets the recommended criteria and may be adapted for the physician office.

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for (specify particular service(s)) for the following reasons: (the physician gives the reason(s) for his or her belief).

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

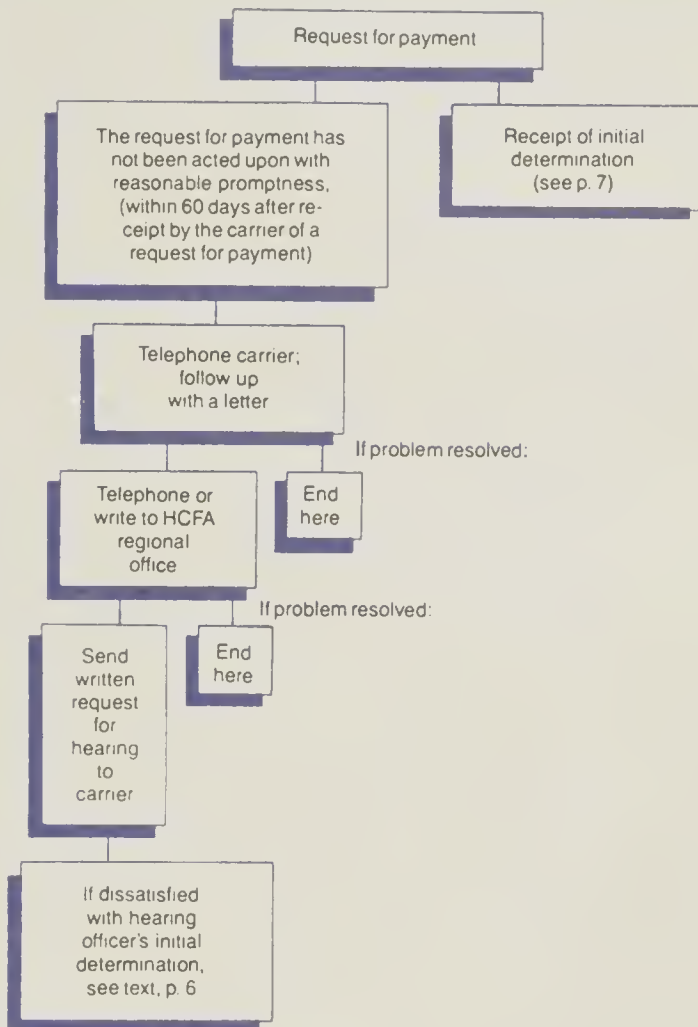
(beneficiary signature)

Rights of Appeal

The appeal process consists of the review, the fair hearing and, for services provided on or after January 1, 1987 (with minimum required amounts in dispute), an appeal before an administrative law judge and review by the federal courts.

If the physician is dissatisfied with the carrier's initial determination, the first step is to request a review. To have a claim reconsidered, a written request for review must be submitted to the carrier within six months after the date of notice of the initial determination. The letter should explain

Process for Expediting an Initial Determination



why the physician is dissatisfied with the decision and contain clear evidence establishing that the physician could not reasonably have known that Medicare would consider the service unnecessary.

Include with the written request:

1. a copy of the original claim submitted;
2. a copy of the carrier's notice of initial determination (EOMB);
3. any additional evidence related to the dispute, such as records that demonstrate the service was indeed necessary, or a copy of a waiver signed by the patient.

The physician will receive written notice of the review determination, stating the results and advising the physician of the right to a fair hearing if initial determination is not reversed. The review is final and binding, unless the fair hearing is requested.

If the physician is dissatisfied with the results of the review and the amount involved is at least \$100, he/she may request a fair hearing. Denied claims within the past six months may be combined to reach the \$100 amount. The physician should carefully consider the time and money involved in an appeal against the potential gains before deciding to request a fair hearing.



To schedule a fair hearing, a written request must be filed with the carrier within six months of the date of notice of the review determination. A hearing officer, an impartial official selected by the carrier presides over the proceedings. The physician will receive written notice of time and location of the hearing and the issues to be determined.

Update

At press time it was learned that Blue Cross Blue Shield of Michigan (BCBSM) has sent physicians a seven-page letter explaining Medicare's new regulations for the "medical necessity" program.

Effective Sept. 1, 1988, participating physicians and physicians who accept assignment are required, in effect, to refund patients when a claim is denied by Medicare as "not reasonable and necessary." A physician who accepts assignment on a claim that is later denied is not by law required to refund the patient but, if he doesn't, Medicare may make the refund to the patient and take it out of future payments to the physician.

However, if the physician can show he had no way of knowing payment would be denied, Medicare will hold neither the physician nor patient liable for *assigned claims*.

The letter provides a model waiver to prewarn patients and get their advance agreement to pay for a service the physician thinks Medicare may deny as medically unnecessary. Physicians are urged 1) To carefully document the necessity of the service and 2) To include with the claim the patient's written agreement to pay for the service any time the physician suspects the claim will be denied — whether it is assigned or unassigned.

The physician must offer a specific reason for why the service may be denied, and the letter provides 14 possible explanations from which the physician may choose.

Preparing for the Hearing

The physician may hire legal counsel, may choose to represent him/herself or waive the right to appear and present evidence personally. If the physician decides to represent him/herself or hire legal assistance, he/she will have the opportunity during the hearing to submit evidence, present oral arguments, respond to the allegations of the carrier and provide and examine witnesses.

The hearing notice will provide useful information about the procedures that will help the physician prepare for the hearing. The physician has the right, under the Freedom of Information Act, to request copies of all records and Medicare regulations that the carrier and hearing officer will be using to determine the case. Requests for this information should be made to the carrier or hearing officer.

At the physician's request, the carrier is required to disclose the internal guidelines that it uses to identify Medicare claims for payment, such as guidelines dealing with length of stay, diagnosis and other criteria used to establish the basis of payment.

The physician may also request specific information on provider cost reports, customary charge screens, prevailing fee information and information from HCFA's *Part B Medicare Carriers Manual*. The carrier must respond to requests within 10 days stating whether the information can be provided and if there will be any delays. If at any time the carrier is unresponsive, the physician should submit a written request to the HCFA regional administrator.

To strengthen the physician's case, a patient's medical records and recommendations of a colleague relating to the appropriateness of the care provided, may be presented. In addition, the patient may be brought in as a witness. Good preparation is extremely important, as the decision of the hearing officer is essentially final. The hearing officer has 120 days from the hearing date to send written notice of his/her decision. For claims where the disputed amount is less than \$500, this decision is essentially final and binding, unless the physician is notified of a specific problem with the case.

New Avenues for Appeal

The Omnibus Budget Reconciliation Act of 1986 provides for subsequent review of a fair hearing before an administrative law judge if the disputed amount is in excess of \$500; and for claims in excess of \$1,000, review by a federal district court judge. This provision applies to services furnished on or after January 1, 1987. An administrative law judge hearing must be requested within 60 days of receipt of the hearing officer's decision.

If, following appeal, the carrier determines that the physician is required to refund any amounts to a patient, the physician and patient are so notified. The physician then has 15 days to refund all amounts. A physician who knowingly and willfully refuses to make refund is subject to assessments of double the violative charges, civil monetary charges up to \$2,000 per violation and/or exclusion from the Medicare program for a period of up to five years.

MSMS and AMA Resources

Questions regarding medical necessity should be directed to Rose B. Heald, MSMS headquarters, 517/337-1351. In addition, the AMA is developing a brochure, to be available soon, that will address many of the issues described above.



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This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS

In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring. In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS

Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS

Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued. Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

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Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

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C I B A

References:

1. Martinez C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium, San Francisco, October 1987.

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Did you know that aspirin has been included in Michigan's over-the-counter Medicaid program for over three years? However, aspirin utilization under the program has remained low, and the cost-savings has been only potential. The main reason for aspirin's underutilization in the program is a lack of awareness among prescribers. The Arthritis Foundation, Michigan Chapter, urges you to keep this policy in mind when prescribing medication.

A prescription is required to take advantage of aspirin inclusion in the Medicaid program, and the following product types are available: Aspirin tablet, 5 gr. or 325 mg.; aspirin tablet, 10 gr., 500 or 650 mg.; aspirin enteric coated tablet, 5 gr. or 325 mg.; aspirin enteric coated tablet 10 gr., 500 or 650 mg.; aspirin and antacid combinations tablets, 5 gr. or 325 mg.

Any questions regarding aspirin in the Medicaid program should be directed to the Medicaid Information Division, Medical Services Administration, P.O. Box 30037, Lansing, MI 48909 or phone toll-free 1-800-292-2550.

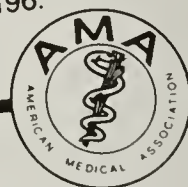
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US med school applications, enrollments down, AMA reports

Applications to US medical schools declined for the 1987-88 academic year and first-time enrollments fell for the sixth year in a row, according to a recent report in the *Journal of the American Medical Association (JAMA)*.

The number of women enrolling in and graduating from medical schools continues to rise, although the number applying has declined, says *JAMA's* 88th Annual Report on Medical Education in the United States. The percentage of medical students from minority groups has changed little over the past few years, although the number of minorities enrolled has fluctuated. However, the number of white males entering medical

school has declined in the past five years, while the number of Black, Asian, and Pacific Islander women has increased substantially, the report says.

There were 3,200 fewer applicants to US medical schools for the 1987-88 academic year than the year before, writes Anne E. Crowley, PhD, of the AMA's Office of Medical Education Information Analysis. Of 28,123 applicants, 17,027 were accepted by at least one school for fall 1987 enrollment.

First-time enrollment totalled 16,047, "a continuation of the decrease observed over the past five years," the report says. Total enrollment, 65,742, also was down for a sixth straight year. "Despite the decline in the number of applicants, the percentage of 'A' students entering has increased and the average Medical College Admission Test score of entering students remains high,"

the authors say.

Women accounted for 37 percent of 1987-88 medical school applicants (58 percent of those applying were accepted), 36.5 percent of entering classes, 34.3 percent of total enrollment, 32.7 percent of MD graduates and 28 percent of residents in graduate medical education programs. Female residents are found in nearly all specialties, but two-thirds are training in family practice, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry.

In discussing minority enrollment, the report looks at ethnic groups underrepresented in medical school when compared with their representation in the overall US population. These groups account for 10.6 percent of the 1987-88 student body—6.2 percent black, 4 percent Hispanics and 0.4 percent native Americans. Ten percent of residents were from underrepresented groups.

Just under 10 percent of students in accredited US medical schools during the 1987-88 year were not US citizens, down sharply from a year earlier. About 16 percent of residents on duty in 1987-88 are foreign medical graduates.

Sinai awarded Skillman grant

The Speech Pathology and Audiology section of Sinai Hospital's Department of Rehabilita-

Continued on page 645

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Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



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INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see DOSAGE AND ADMINISTRATION). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see DOSAGE AND ADMINISTRATION).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.

Carcinogenesis, Mutagenesis, and impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio. HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX[®] (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX[®] is usually applied to the affected area twice daily in the morning and evening. MYTREX[®] should be discontinued if symptoms persist after 25 days of therapy. (See PRECAUTIONS, Laboratory Tests). MYTREX[®] should not be used with occlusive dressings.

Caution: Federal law prohibits dispensing without prescription.



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NEWSFRONTS/Continued

ion Medicine will receive \$60,000 from the Skillman Foundation to provide speech pathology services for needy children. The 18 month program will help children with speech and/or language disorders who are at high risk for developing learning disabilities.

The addition of a reading component makes this speech pathology program unique. The program will include training Sinai

speech pathologists to deliver the reading and writing assessment tests and will test, treat and evaluate the children. Most of the funds will be used for therapy.

Program coordinator and speech pathologist Karen O'Leary says, "Reading and writing problems in children are often misunderstood. These problems are usually attributed to visual perceptual problems when, in fact, reading and writing problems are based on difficulties with listening and speaking."

O'Leary adds that this pro-

gram is aimed at children whose listening and speaking problems have already been diagnosed.

The Skillman Foundation was founded in December of 1960 by Rose P. Skillman, widow of Robert H. Skillman, vice-president and director of Minnesota Mining and Manufacturing Company.

Qualified children in Detroit and its suburbs, including Birmingham, Milford, Bloomfield, Farmington and Southfield, can

Continued on next page



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NEWSFRONTS/Continued

benefit from the program, both at the main hospital in Detroit and at Sinai's Goldin Health Care Center in West Bloomfield. For more information about the program, call Karen O'Leary at (313) 661-9400.

ACEP develops DNR guidelines

Responding to the fact that the terminally ill patient who does

not wish to be resuscitated has not been well addressed in the prehospital environment, the American College of Emergency Physicians (ACEP) has developed *Guidelines for Do Not Resuscitate Orders in the Prehospital Setting*.

While many efforts have focused on the development of do not resuscitate policies in the inpatient setting, no clearly defined, uniform policies for dealing with emergency situations in the prehospital environment involving the terminally ill have been developed.

It is not the purpose of ACEP's do not resuscitate document to establish criteria for determining whether resuscitative efforts should be initiated in an individual patient, but to suggest guidelines by which policies can be developed in local, regional and state emergency medical services systems (EMSS) in matters of withholding cardiopulmonary resuscitation in those patients known to have a terminal medical condition.

Continued on page 648

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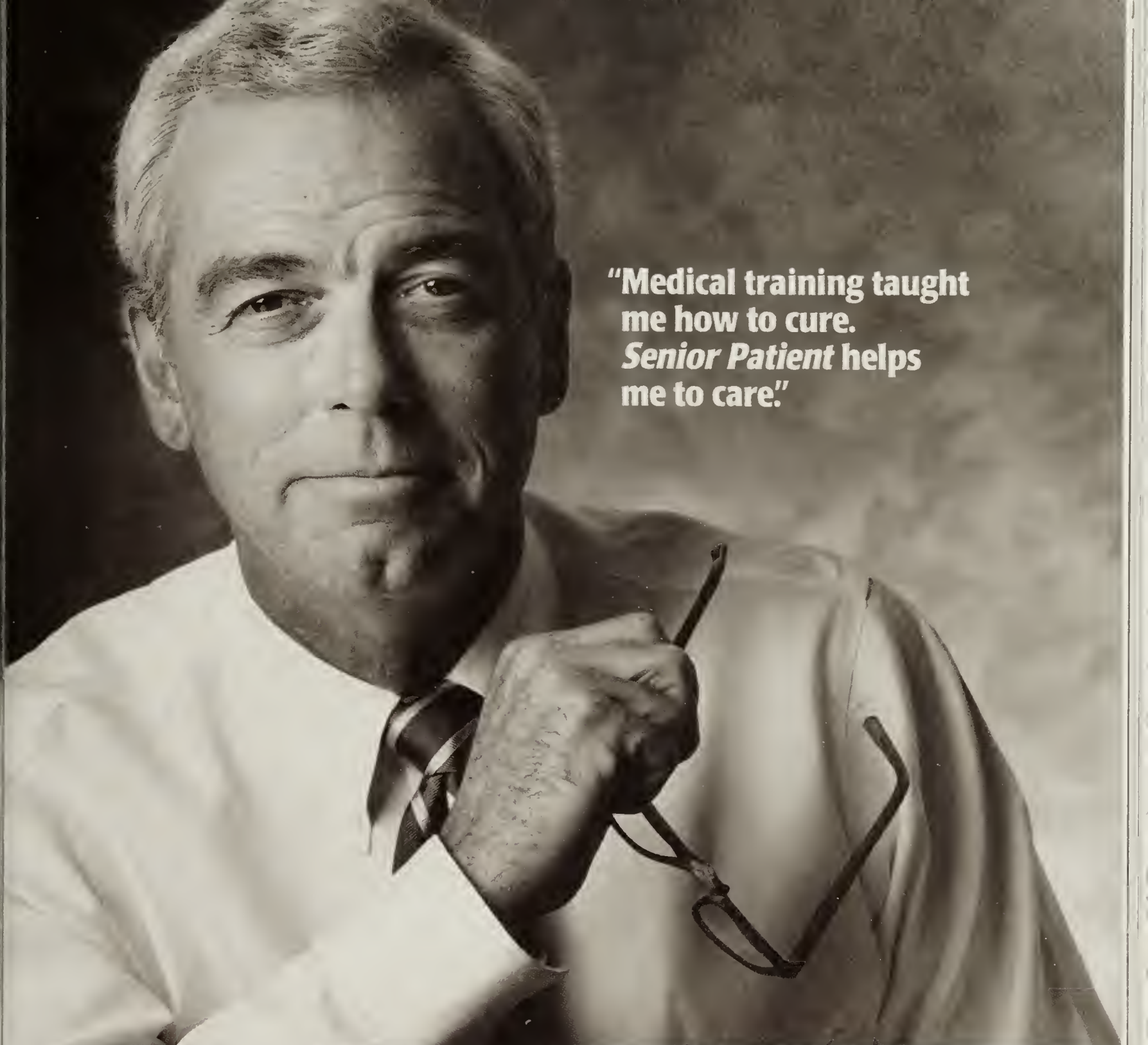
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NEWSFRONTS/Continued

Copies of *Guidelines for Do Not Resuscitate Orders in the Prehospital Setting* may be obtained by contacting the ACEP Distribution Center in Irving, Texas at (214) 550-0911.

Heart arteries implants successful, U-M reports

A tiny steel mesh tube called a stent that holds open heart arteries likely to close has been implanted successfully in two patients at The University of Michigan Medical Center.

The procedure has been performed successfully on only seven patients in the United States. The U-M is one of four medical centers in the country—and the only one in the Midwest—to have used the experimental device.

The stent is used when blood vessels in a patient's heart become blocked by plaque repeatedly, even after having been opened by coronary angioplasty. Using the stent to hold open an artery may help prevent the need for further angioplasty or bypass surgery, according to the U-M physicians who performed the procedures, Stephen G. Ellis, MD, assistant professor internal medicine, and Eric J. Topol, MD, associate professor of internal medicine.

When arteries in the heart are partially blocked by plaque, the reduced blood supply results in chest pain; total blockage cuts off

blood flow and results in a heart attack. Angioplasty, a less invasive alternative to bypass surgery, uses a balloontipped catheter to compress plaque against the walls of the blood vessel and restore blood flow to the heart muscle.

Angioplasty, which is now used on 200,000 patients annually in the United States, is effective for most people. However, about 25 percent will have blockages recur and will require further treatment, Doctor Ellis said.

"The stent acts as a buttress to prop the artery open, hopefully reducing the risk of recurrent blockage and heart attacks," he explained.

At the UM Medical Center, the stent procedure has been performed on two persons—a 69-year-old man whose blockage has recurred four times after angioplasty, and a 56-year-old man who has recently suffered a heart attack. Both patients have since been released from the hospital after passing an exercise test, and both feel well.

MEI chosen for FDA approved study

The Michigan Ear Institute was one of ten centers selected to participate in a clinical study conditionally approved by the FDA to study the Nucleus 22 channel cochlear implant in adults who have a severe hearing loss.

Until now, cochlear implants have been restricted to the profoundly deaf, those who cannot understand any speech with hearing aids.

The study was launched after observing the improved communication abilities demonstrated by 22 Channel cochlear implant recipients who lost their hearing after learning language.

Under the new study, the Nucleus 22 Channel cochlear implant will be implanted in adults who are getting less speech discrimination from hearing aids than average cochlear implant recipients derive from their implants.

"Among the inquiries we receive about cochlear implants, the most frustrated people are those who have some hearing and are wearing hearing aids, but are getting very little benefit from them," says T. Manford McGee, MD, of the Michigan Ear Institute. "Because these people have some residual hearing, we hope that they will be able to derive even greater benefit from a multichannel cochlear implant than totally deaf individuals."

Fetzer Foundation supports chelation therapy

Research to gain Food and Drug Administration (FDA) approval of chelation therapy for clogged arteries, an often contro-

Continued on page 650

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NEWSFRONTS/Continued

versial medical treatment, is being supported by the John E. Fetzer Foundation, Kalamazoo.

The chelation project is among several programs and activities recently receiving Fetzer Foundation assistance totaling \$370,750.

Chelation therapy is an approved treatment for several conditions: (1) to decrease blood calcium when it becomes critically high in some cancers; (2) to re-

move lead and some radioactive metals from the body; and (3) to overcome the toxic effects of some heart medications, such as digitalis.

The \$2.2 million project will be monitored by Doctor Martin Rubin, professor emeritus of biochemistry at Georgetown University in Washington, DC, and president of the International Chelation Research Foundation. The Fetzer Foundation is contributing \$105,000 of the amount and is one of several participating organizations providing outright

grants, in-kind services and use of facilities.

The research will take place simultaneously at two "highly respected" medical institutions, Doctor Rubin said.

Because of the controversial nature of the research, the FDA is requiring that the sites and the principal investigators not be identified until after the conclusion of the study. □

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[†]Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

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Skin and Skin Structure Infections caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Proteus vulgaris*, *Providencia stuartii*, *Morganella morganii*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis*, and *Streptococcus pyogenes*.

Bone and Joint Infections caused by *Enterobacter cloacae*, *Serratia marcescens*, and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Serratia marcescens*, *Proteus mirabilis*, *Providencia rettgeri*, *Morganella morganii*, *Citrobacter diversus*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus epidermidis*, and *Streptococcus pyogenes*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni*, *Shigella flexneri*,* and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro[®] may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, enoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
 - E. coli* DNA Repair Assay (Negative)
 - Mouse Lymphoma Cell Forward Mutation Assay (Positive)
 - Chinese Hamster V₇₉ Cell HGPRT Test (Negative)
 - Syrian Hamster Embryo Cell Transformation Assay (Negative)
 - Saccharomyces cerevisiae* Point Mutation Assay (Negative)
 - Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
 - Rat Hepatocyte DNA Repair Assay (Positive)
- Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:
- Rat Hepatocyte DNA Repair Assay
 - Micronucleus Test (Mice)
 - Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy - Pregnancy Category C.

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in

CONVENIENT **B.I.D.** DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dose
Respiratory Tract*	Mild/Moderate	500 mg B.I.D.
Bone and Joint*	Severe/Complicated	750 mg B.I.D.
Skin/Skin Structure*	Mild/Moderate	250 mg B.I.D.
	Severe/Complicated	500 mg B.I.D.
Urinary Tract*	Mild/Moderate/Severe	500 mg B.I.D.

pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers:

It is not known whether ciprofloxacin is excreted in human milk; however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use:

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse reaction in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those terms in italics are italicized.

GASTROINTESTINAL (See above), painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, erythema nodosum.

CENTRAL NERVOUS SYSTEM (See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.

SKIN/HYPERSENSITIVITY (See above), pruritus, urticaria, photosensitivity, flushing, fever, angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyperpigmentation.

SPECIAL SENSES blurred vision, disturbed vision, (change in color perception, overbrightness or decreased visual acuity, diplopia, eye pain, tinnitus, bad taste).

MUSCULOSKELETAL joint or back pain, joint stiffness, achiness, neck or chest pain, flare-up of gout.

RENAL/UROGENITAL interstitial nephritis, renal failure, polyuria, urinary retention, urethral burning, vaginitis, acidosis.

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccup, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were just what investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to relationship.

Hepatic - Elevations of ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH serum bilirubin (0.3%).

Hematologic - eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated platelets (0.1%), pancytopenia (0.1%).

Renal - Elevations of Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINORURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gamma-glutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with severe or complicated infections, 500 mg may be administered every 12 hours.

For patients with respiratory tract infections, skin and skin structure infections, and bone and joint infections may be given 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro[®] (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50. Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

* Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.

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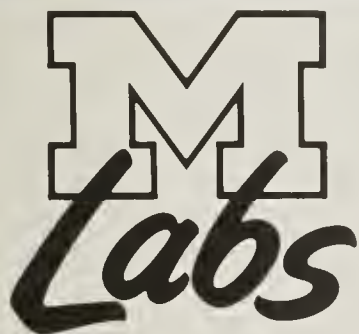


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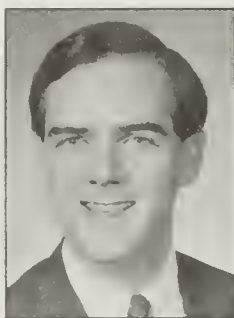
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PHYSICIANS IN THE NEWS



Cutler



Baubie

Michigan Academy of Family Practitioners recently elected James F. Shetlar, MD, Frankenthum, as president and Larry S. Kelly, MD, Saginaw, as president-elect at the group's annual meeting in July.... Debra Ann Rothenberg, East Lansing, is one of 33 undergraduate medical students awarded the SmithKline Beckman Medical Perspectives Fellowships by the National Fund for Medical Education, Boston, Massachusetts. The applicants are enrolled in schools throughout the United States which offer MD and DO degree's.... David M. Magyar, DO, and Maria F. Hayes, MD, have joined the medical staff of Oakwood Hospital, Dearborn. Doctors Magyar and Hayes will head Oakwood's new Division of Reproductive Endocrinology and Infertility, a recent addition to the Hospital's Women and Children's Health Care Center.... St. Joseph Mercy Hospital internist, Michael J. Baker, MD, who is on the teaching staff at the Pontiac hospital, recently received an "Excellence in Teaching" award from the resident staff. It is the second time the doctor has received the award. The first was



Doctor Rodger

The late John Rodger, MD, Bellaire family physician for 43 years until his retirement in 1978, was recalled this summer in an outpouring of articles and letters

to the editor in the local newspaper. Following his death April 23, former patients and fellow townspeople praised his dedication and love through their writings in the *Antrim County News*. Doctor Rodger delivered 2,300 babies, served as founder and medical director for 30 years of the Meadow Brook Medical Care Facility in Bellaire, and has a local elementary school named in his honor. Doctor Rodger also was past-president of the Northern Michigan Medical Society, and chaired the MSMS Rural Health Committee.



Canady



Goyert

in 1986.... The American Academy of Family Physicians has named Campbell Cutler, MD, Flint, "Physician of the Year" for his volunteer work in Third World countries and for his work closer-to-home at McLaren General Hospital.... William Baubie, MD, Grosse Pointe Farms, has been selected by the American Academy of Medical Directors and the University of Wisconsin Medical School as an inaugural fellow to participate in a graduate-level program for a masters of science degree in ad-

ministrative medicine at the UW Medicine School.... Mercy College of Detroit honored Alexa Canady, MD, pediatric neurosurgeon at Children's Hospital of Michigan, at the annual Works of Mercy dinner September 8. Canady received the Mercy Medallion, given by the institution to individuals whose lives and activities are examples of traditional or contemporary works of mercy.... Gregory L. Goyert, MD, has been appointed assistant director of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, Sinai Hospital, Detroit. In addition to his new assignment, Doctor Goyert is assistant professor in the Department of Obstetrics and Gynecology, Wayne State School of Medicine. □

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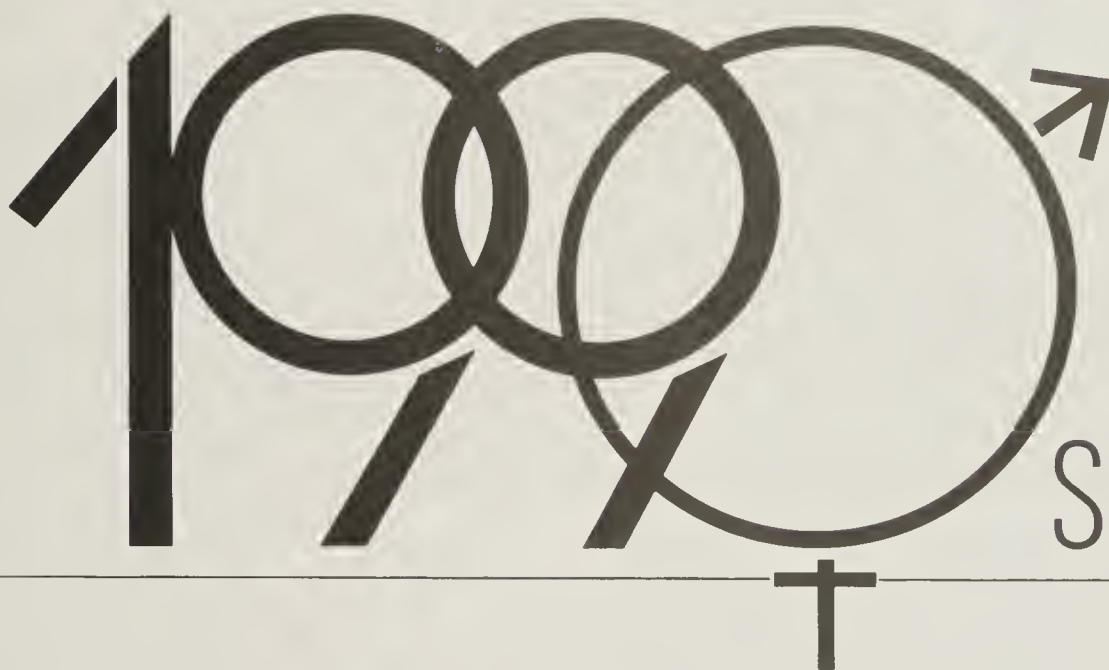
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William M. Chavis, MD — Director, Wayne State University/Hutzel Hospital Center for Sexual Health; Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine, Detroit, Michigan.

Sexuality and Medical Care in the 1990s

John J. LaFerla, MD — Director of General Gynecology, Hutzel Hospital; Consultant, Wayne State University/Hutzel Hospital Center for Sexual Health; Associate Professor of Obstetrics and Gynecology, and Psychiatry, Wayne State University School of Medicine, Detroit, Michigan.

The Physiology and Classification of Sexual Dysfunction

Steven Levine, MD — Medical Director of Center for Human Sexuality, and Head, Sexual Dysfunction Clinic, University Hospital; Professor of Psychiatry, Case Western Reserve University School of Medicine, Cleveland, Ohio.

Management of Sexual Dysfunction in Office Practice

Dennis J. Munjack, MD — Associate Professor of Psychiatry, Director of Anxiety Disorders Clinic and Sexual Problems Unit, University of Southern California - LA County Medical Center, Los Angeles, California.

Sexuality in the Menopause Years

Steven Jay Ory, MD — Associate Professor, Consultant and Chairman, Section of Reproductive Endocrinology and Fertility, Department of Obstetrics and Gynecology, Mayo Clinic and Mayo Graduate School of Medicine, Rochester, Minnesota.

Meeting the Needs of Your Lesbian and Gay Male Patients

Kathy Sarris — Executive Director, Michigan Organization for Human Rights.

James Toy — Gay Male Programs Coordinator, University of Michigan, Ann Arbor, Michigan.

Male Sexuality

William Lamar Weems, MD — Professor and Director, Division of Urology, University of Mississippi Medical Center, Jackson, Mississippi.

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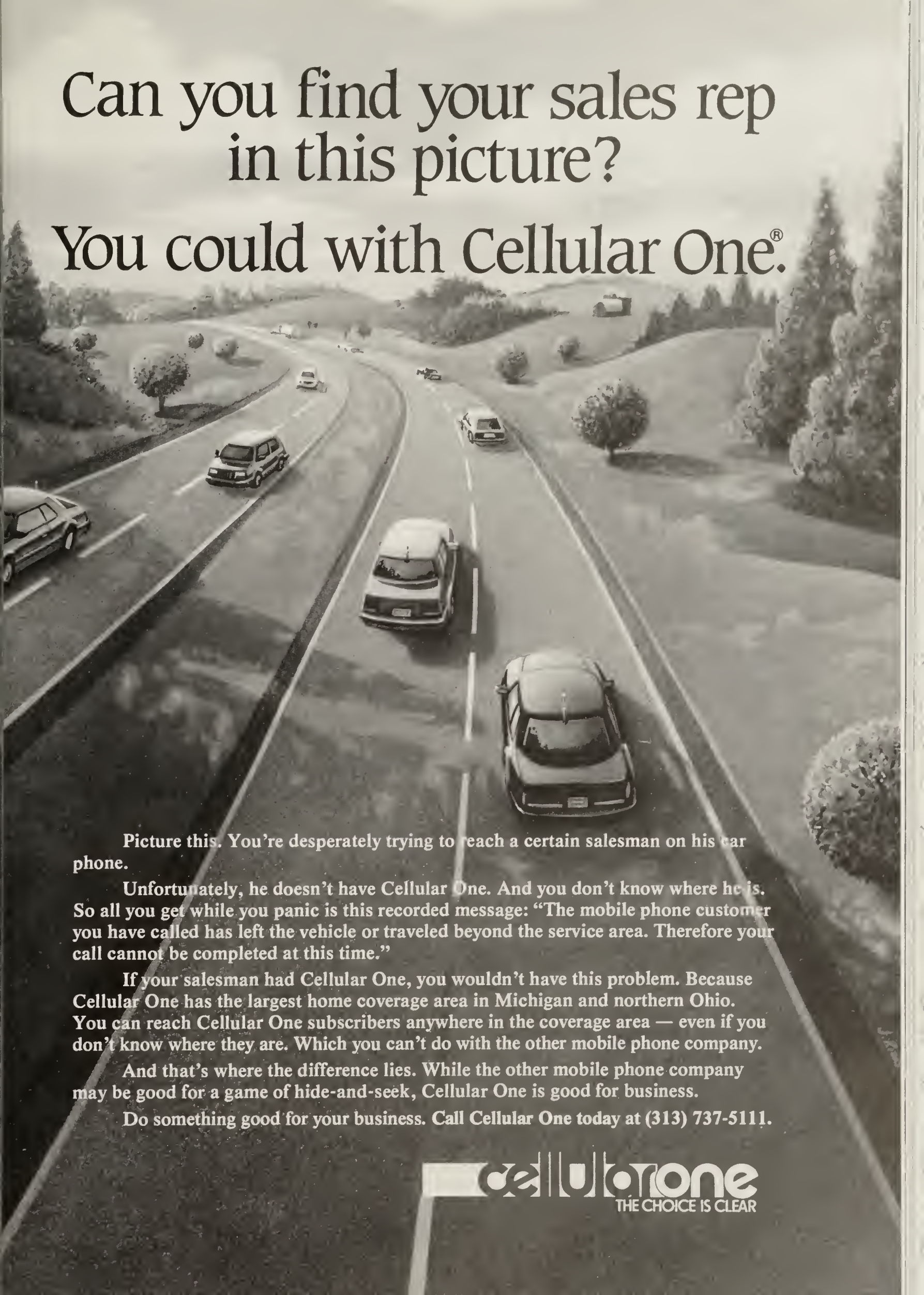
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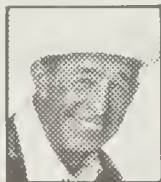


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GOLF Cruise WITH THE PROS



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Sam Snead



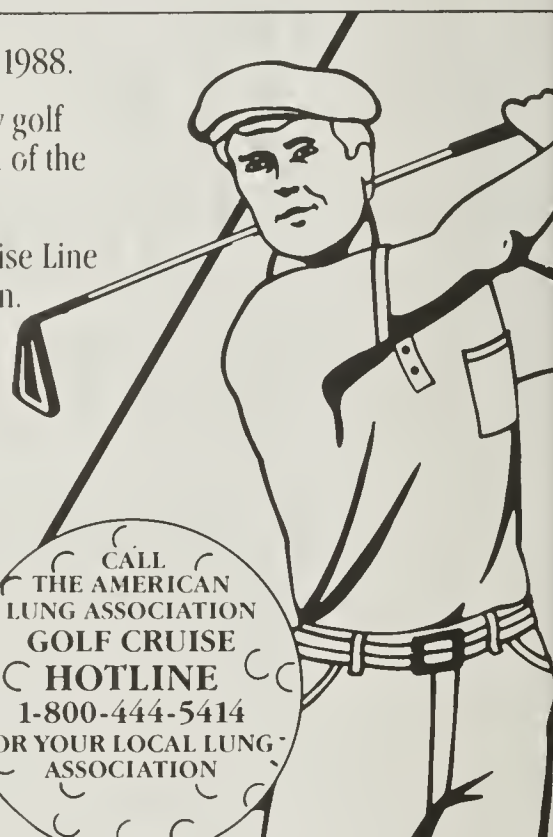
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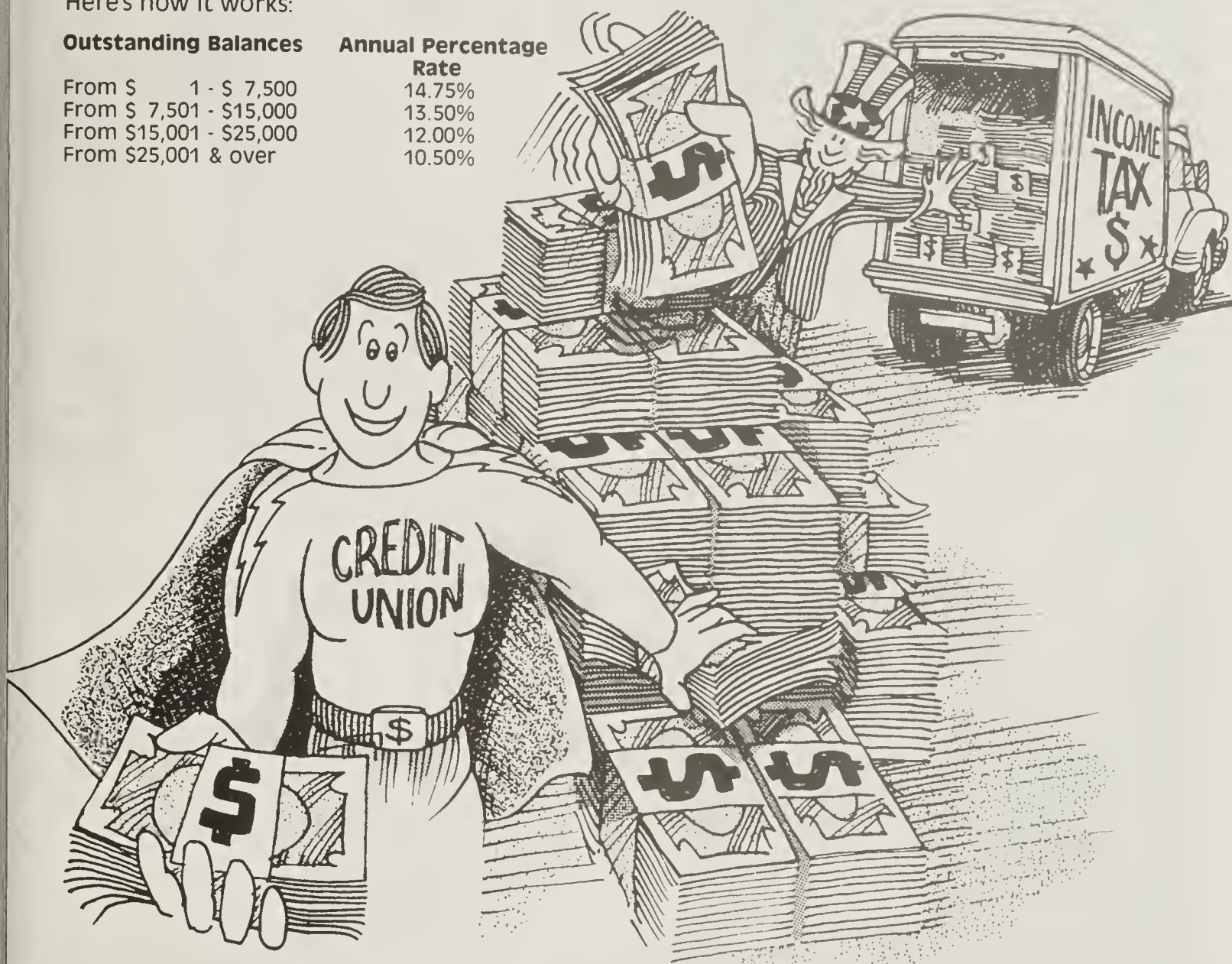


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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

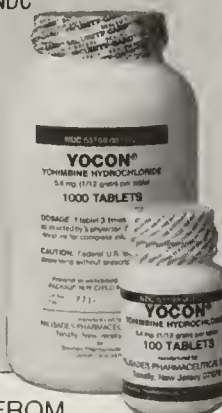
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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DEATHS

Bernard J. Dowd, MD Kalamazoo

Doctor Dowd, a Kalamazoo general practitioner, died July 2 at the age of 82. He was a 1933 graduate of Northwestern University. He was affiliated with Borgess and Bronson Methodist Hospitals, Kalamazoo. He served in the Medical Military Service from 1942 to 1946.

Henry L. Jenkins, MD Pontiac

Doctor Jenkins died June 30 at the age of 63. He was a 1954 graduate of Howard University, Washington, DC. He served his internship at Pontiac General Hospital and his residency at University Hospital, Ann Arbor, where he specialized in general surgery. He had been in private practice in Pontiac since 1959. Doctor Jenkins was on the staffs of Pontiac General Hospital and St. Joseph Mercy Hospital at the time of his death. He was a member of the Oakland County Medical Society, American Medical Association, NAACP, and the Pontiac Urban League. He formerly was on the Oakland County Medical Society board of directors. Doctor Jenkins served from 1943 to 1946 in New Guinea and the Philippines with the US Army.

Earl J. Knaggs, MD Southgate

Doctor Knaggs, a Wyandotte general practitioner for 38 years, died June 17 at the age of 82.

Doctor Knaggs graduated from the University of Michigan in 1929 with a degree in pharmacy and from the U-M Medical School in 1933. He completed his internship at Flint's Hurley Hospital and his residency at Lapeer State Hospital. Doctor Knaggs served as an Army medical officer in Europe and the US during World War II.

James K. Sutherland, MD Flint

Doctor Sutherland died June 15 at the age of 91. He was a general practitioner in Flint and specialized in cardiovascular diseases. A 1926 graduate of the University of Iowa, he was affiliated with Hurley, St. Joseph, and McLaren General hospitals. He also served as coroner of Genesee County from 1932 to 1952.

Timothy Truman, MD Saginaw

Doctor Truman, a Saginaw pediatric cardiologist and intensivist, died June 4 at the age of 42. He was a graduate of the Michigan State University College of Human Medicine and was a member of the AMA and the Saginaw County Medical Society. He did his residency at Grady Memorial Hospital in Atlanta, Ga, and received a fellowship from Children's Hospital, Boston, in 1979.

W. Clarence Beets, MD Grand Rapids

Doctor Beets, a general prac-

titioner and internal medicine specialist, died July 5 at the age of 87. Doctor Beets was a delegate to MSMS and president of the Henry Beets Missionary Society at LaGraves Avenue Christian Reformed Church. He was a founding member of Jellema House for the treatment of alcoholics and was a cofounder of the Kent Medical Foundation. He was a 1928 graduate of the University of Michigan Medical School.

Sidney Charnas, MD Birmingham

Doctor Charnas, former chief of staff of Providence Hospital, Southfield, died June 21 at the age of 73. He earned his medical degree at Wayne State University in 1940. He then served his orthopedic residency at Children's Hospital, Oklahoma. He served from 1943-1946 with the Army in England and Germany, then returned to Detroit and began private practice in orthopedic surgery. He was president of the Detroit Academy of Orthopedic Surgeons in 1964.

William Gibson, MD Detroit

A Detroit physician for 31 years and the first black in the nation to be certified as a cardiologist, Doctor Gibson died June 23 at the age of 61. He graduated from Howard University Medical School, interned at District of Columbia General Hospital and served his residency at Boston City College. He served in

he Army Medical Corps during the Korean War, and became one of the first black doctors at Harper Hospital. He was a member of the American Medical Association, Wayne County and Detroit Medical Societies, the staffs of Hutzel and Providence hospitals, and was a fellow of the American College of Physicians.

John A. Kleber, MD
South Haven

Doctor Kleber, a family practitioner for more than 40 years in

the South Haven area, died June 16 at the age 73. He was a member of the AMA, a diplomate of the American Board of Family Practitioners, a fellow of the American College of Family Practitioners, a member of the American Association of Abdominal Surgeons, and a member and past president of Van Buren County Medical Society.

James W. Lasley, MD
Bloomfield Hills

Doctor Lasley died June 25 at

the age of 79. A surgeon, he held a private practice in the Detroit area for 45 years. He was also a medical consultant for Blue Cross & Blue Shield of Michigan. Doctor Lasley graduated in 1934 from the University of Michigan and completed his internship and residency at Harper Hospital. He served in the U.S. Navy during World War II.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

October

14, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category I Credit.

14-15, 1988 Michigan Statewide Conference on Child Abuse and Neglect: Strategies for Successful Prevention and Treatment. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 11 hours Category I Credit.

15, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 7 hours Category I Credit.

17-18, The Dilemma of the Complications of Diabetes. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, The Michigan Diabetes Research and Training Center, The Michigan Affiliate of the American Diabetes Association. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 13 hours Category I Credit.

22, Cardiovascular Update. Location: Bay Valley Hotel and Resort, Bay City. Sponsor: Bay Medical Education. Contact: Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City 48708 (517) 892-1501. Approved for: 5 hours Category I Credit.

28, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category I Credit.

29-30, Advanced Cardiac Life Support Provider Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 16 hours Category I Credit.

31-11/2, Pediatric Emergencies: A Review and Update. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School 48109-0201 (313) 763-1400. Approved for: 19 hours Category I Credit.

November

2, Fifth Annual Conference on Alcoholism and Other Drug Dependencies. Location: Genevieve U. and Donald S. Gilmore Center for Health Education, Kalamazoo. Sponsor: Gateway Villa, KADAC, Southwestern Michigan Area Health Education Center. Contact: Continuing Medical Education Department, Southwestern Michigan Area Health Educa-

tion Center (616) 341-6360. Approved for: 6 hours Category I Credit.

3-4, Ear, Nose and Throat Practicum. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 19 hours Category I Credit.

3-4, Critical Clinical Issues in the Care of the Elderly: Reversing Critical Dysfunction. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School Geriatric Center, Division of Geriatric Medicine, Department of Internal Medicine, The University of Michigan Institute of Gerontology and Ann Arbor Veterans Administration Medical Center. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 14 hours Category I Credit.

11-12, 36th Annual Detroit Trauma Symposium. Location: Harper Hospital, Detroit. Sponsor: Wayne State University, Harper Hospital, Department of Surgery. Contact: Marjorie Norum, Department of Surgery, Harper Hospital, 3990 John R, Detroit 48201 (313) 745-2345. Approved for: 8.5 hours Category I Credit.

15, Behavioral and Medical Perspectives of Obesity and Eating Disorders. Location: Henry Ford Hospital, 2799 West Grand Blvd., Detroit. Sponsor: Henry Ford Hospital. Contact: Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 6.5 hours Category I Credit.

18, Psychiatry for the Primary Care Physician. Location: Henry Ford Hospital, 2799 West Grand Blvd., Detroit. Sponsor: Henry Ford Hospital. Contact: Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 6 hours Category I Credit.

29, Heart Disease: Evolving Concepts. Location: Somerset Inn, Troy. Sponsor: American Heart Association of Michigan. Contact: Lori Hall, Program Consultant, American Heart Association of Michigan, 16310 W. 12 Mile Road, P.O. Box 160, Lathrup Village 48076 (313) 557-9500. Approved for: 6 hours

Category 1 Credit.

30, Diabetes Mellitus: Sexuality, Pregnancy and Aging. Location: Fairlane Manor, Dearborn. Sponsor: Henry Ford Hospital. Contact: Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 7.5 hours Category 1 Credit.

December

4-5, The Difficult Airway. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 13 hours Category 1 Credit.

9, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category 1 Credit.

10, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 7 hours Category 1 Credit.

January

13, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category 1 Credit.

14-15, Advanced Cardiac Life Support Provider Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor:

University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 16 hours Category 1 Credit.

29-2/3, The Thirteenth Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbour Springs. Sponsor: University of Michigan Medical School, Department of Family Practice with the Michigan Academy of Family Physicians, and Department of Postgraduate Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 20 hours Category 1 Credit.

February

10, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category 1 Credit.

11, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 7 hours Category 1 Credit.

10-12, Advanced Cardiac Life Support Instructor Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 21 hours Category 1 Credit.

13-17, Eighth Postgraduate Course on Myocardial Infarction and Angina Pectoris. Location: Convention Center, Davos, Switzerland. Sponsor: University of Michigan Medical School, Hanover Medical School, Hanover, West Germany. Contact: Karen McCalla, Marketing Assistant, Office of Continuing Medical Education, Towsley Center,

Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 28 hours Category 1 Credit.

27-3/3, Microvascular Workshop for Otolaryngologists and Head and Neck Reconstructive Surgeons. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery, and American Academy of Facial Plastic and Reconstructive Surgery. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 30 hours Category 1 Credit.

March

2-4, Advances in the Management of Infectious Diseases. Location: South Seas Plantation, Captiva Island, Florida. Sponsor: University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 12 hours Category 1 Credit.

9-14, 12th Annual Ophthalmology: Basic and Clinical Review Course. Location: Wayne State University School of Medicine, Detroit. Sponsor: Kresge Eye Institute of Wayne State University School of Medicine. Contact: Division of Continuing Medical Education, Wayne State University School of Medicine, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313) 577-1180. Approved for: 42 hours Category 1 Credit.

14-18, Family Practice-1989 Thirteenth Annual Spring Review Course. Location: Towsley Center, University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Family Practice and the Michigan Academy of Family Physicians. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 34 hours Category 1 Credit.

MEETINGS

MSMS MEETINGS

October

15, Primary Care Medicine Seminar, Hidden Valley, M-32 East, Gaylord, in cooperation with MSMS AIDS Speaker's Bureau, contact: Dr. Matias, 429 N. Center, Gaylord 49735, (517) 732-3514 or Lisa Strother, P.O. Box 950, East Lansing 48826-0950, (517) 337-1351.

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517) 337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

January

18, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

March

8, MSMS Board of Directors Meetings, MSMS headquarters, contact: William Madigan (517) 337-1351.

AMA MEETINGS

October

26, Research Symposium on Drug Abuse, Chicago Marriott, American Medical Association and the Association for Medical Education and Research in Substance Abuse (AMERSA) and National Institute on Drug Abuse (NIDA), contact: American Medical Association, 535 North Dearborn St., Chicago, IL 60610, 1-800-621-8335.

27-28, Innovation Imperiled? Medical Technology in an Era of Cost Containment, O'Hare Marriott Hotel, Chicago, American Medical Association and the Health Policy Agenda for the American People, contact: American Medical Association, 535 N. Dearborn St., Chicago, IL 60610, 1-800-621-8335.

26-30, AMA Ninth National Conference Impaired Health Professionals: Visions and Values, Chicago, contact: AMA, 535 North Dearborn St., Chicago, IL 60610, (312) 645-4344.

December

4-7, AMA Interim Meeting, Dallas, Texas, contact: AMA, 535 North Dearborn St., Chicago, IL 60610, (312) 645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

May

4-5, Michigan Chapter, American College of Surgeons Coller Competition and Annual Meeting, Sheraton University Inn, Ann Arbor, contact: Viola M. Heins, P.O. Box 950, East Lansing 48826-0950, (517) 337-1351.

NATIONAL SPECIALTY SOCIETY MEETINGS

October

17-19, American College of Gastroenterology Annual Meeting, Hilton, New York, NY, contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944, (617) 927-8330.

23-28, American College of Surgeons Annual Meeting, Hilton, Chicago, IL, contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611, (312) 664-4050.

26-30, American Academy of Child

and Adolescent Psychiatry Annual Meeting, Westin Hotel, Seattle, WA, contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.E., Washington, DC 20016, (202) 966-7300.

30-11/4, American Academy of Physical Medicine and Rehabilitation Annual Scientific Meeting, Convention Center, Seattle, WA, contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603 (312) 922-9366.

31-11/5, American Academy of Pediatrics Annual Meeting, San Francisco, CA, contact: American Academy of Pediatrics, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007 (312)288-5005.

November

2-5, The Wrist 1988, American Society for Surgery of the Hand, Saddlebrook Resort, Tampa, FL, contact: American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014, (303) 755-4588.

12-16, American College of Allergists Annual Scientific Meeting, Westin Century Plaza, Los Angeles, CA, contact: American College of Allergists, 800 E. Northwest Highway, Suite 101, Mt. Prospect, IL 60056, (312) 255-0380.

December

3-8, American Academy of Dermatology Annual Scientific Meeting, Washington, DC, contact: American Academy of Dermatology, 1567 Maple Avenue, P.O. Box 3116, Evanston, IL 60204-3116, (312) 869-3954.

OTHER MEETINGS

October

14-16, Sepulveda Epilepsy Education Program, Ann Arbor, contact: The

Reverend Charles H. Swinehart, Jr.,
Epilepsy Support Services, 6159 Aldine
Drive, Brighton, 48116, (313) 229-4193.

**16-19, Mental Health 1990s: Partner-
ships and Strategies, Cobo Conference/
Exhibition Center, Detroit, contact:**
Michigan Department of Mental Health,
P.O. Box 30182, Lansing 48909.

November

3-4, Family Practice Research Day XII:
Research in the Residency, The Univer-
sity Club, Michigan State University
Campus, East Lansing, contact: Douglas
B. McKeag, MD, Chairman, Michigan
Family Practice Research Day XII, B-

100 Clinical Center, Michigan State Uni-
versity, East Lansing 48824, (517)
353-0772.

**16, Obesity in Children: Assessment
and Management, Kellogg Center for
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Clinician's Carnival — The Big Top's back in town

By Fred W. Bryant, MD

The MSMS Annual Scientific Meeting is about to get underway. Generally, the courses are full of goodies — something old, something new; a broad review of ageless problems combined with a convenient summary of recent advances. Others make a compact single-issue presentation, shooting darts at intense problems with narrow amplitude geared to specialists. In other ways, the ASM is a theme park of novel and trendy issues.

There are noteworthy programs, some of them “double dips,” approaching a single problem on more than one occasion. The unique plenary eye-opener on Wednesday morning is a solo performance by James Curran, MD, of the Centers for Disease Control, who has a Michigan background. In the afternoon he makes a sequel appearance with other experts on AIDS.

Lasers I and II also pack a one-two punch, describing the basic technology, then moving to its use in various specialties.

Attendees will have a unique opportunity to listen to and question two Michigan legislators about health care for the elderly.

Doctor Bryant, MSMS president, has worked behind the scenes for several years to help make the Annual Scientific Meeting a worthwhile event. He has served as an ophthalmology course coordinator, member of the ASM Planning Committee and chairman of the MSMS Board's Scientific and Educational Affairs Reference Committee.



Doctor Bryant

Congressman Sander Levin and State Representative David Hollister, both of whom are interested in the health of Michigan's citizens, will participate in a panel discussion on financing long-term care.

The courses are the core of the ASM and the reason for its existence, but there are other attractions. The poster exhibits will be near the entrance to the main hall where they are not likely to be overlooked. This year the prize winners will be determined by W. Donald Weston, MD, the affable dean of the Michigan State University School of Medicine, who has always shown interest in the ASM.

There will be 70 booths arranged several avenues deep to offer opportunities to chat with exhibitors and to examine their products and services. In the same vicinity will be the snack area, where coffee, soft drinks and popcorn will be available.

And so, Michigan Medicine's “monster midway” is ready to open again. The offerings are: 55

courses, a dozen and a half each for three days; almost a score of posters on display; 70 exhibits with 300 exhibitors on hand; a cadre of 55 course directors and 200 speakers addressing several hundred attendees who will earn seven to eight thousand education credit hours.

Some words of praise are in order for the MSMS “carnival ground crew,” who sally forth to set the site — figuratively to drive the stakes, raise the center pole and erect the big top.

This year nearly three dozen MSMS staff members will travel from East Lansing to Dearborn — gandy dancers maintaining the supply line. They are the “on-the-scene” lifeblood of the meeting.

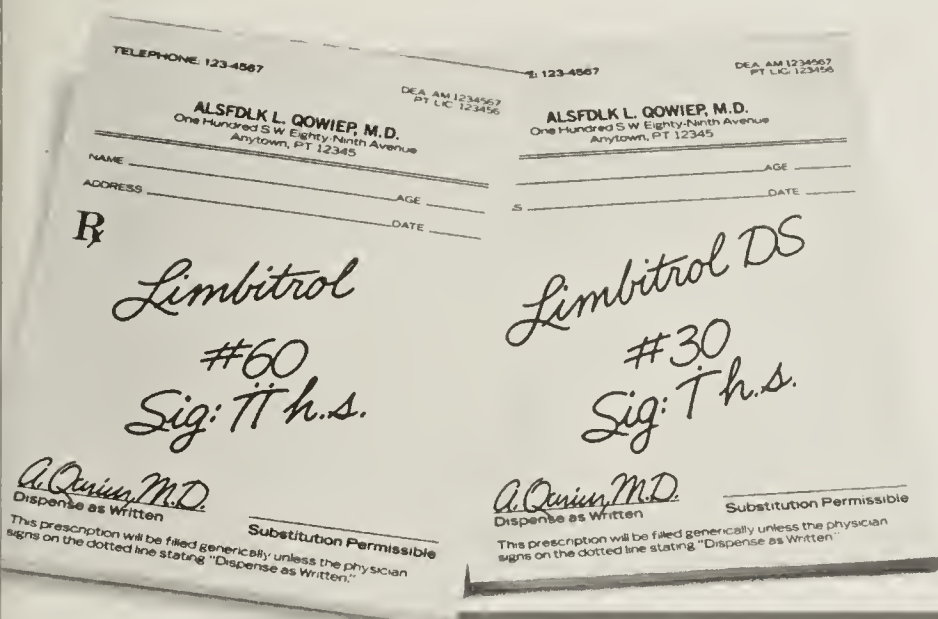
A special thank you is in order for members of the ASM Planning Committee, the Committee on Continuing Medical Education, and, last but not least, to Joan Stryker, MD, ASM chairman.

Kudos to Sherry Fent, MSMS Chief of Physician Education, for developing the program, and to Linda Munson, MSMS Chief of Meeting Planning, for coordinating physical arrangements and the exhibit area.

The shrill voice of the shill can be heard exhorting you to share the fare and sample the wares at this year's ASM. Those who attend will find it worth the price of admission. Hurry! Hurry! Hurry! □

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

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Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

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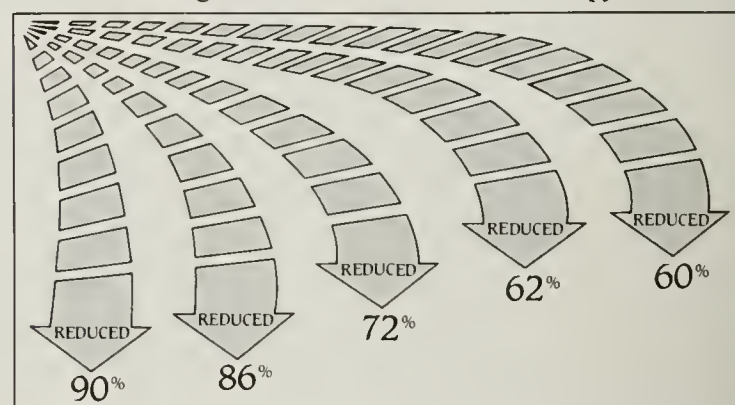
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M I C H I G A N MEDICINE

NOVEMBER 1988

AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

VOL. 87, No. 11

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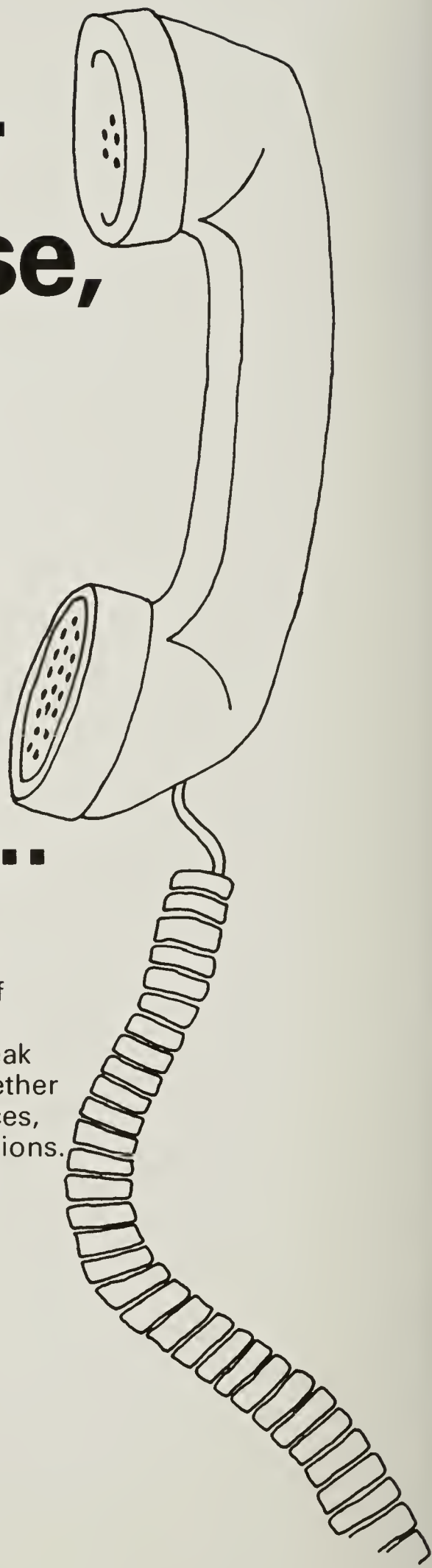
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M I C H I G A N MEDICINE

NOVEMBER 1988 VOL. 87, No. 11

Special Report

Now, more than ever before, membership in organized medicine is vitally important. That's the message of Dorothy Kahkonen, MD, chairman of the MSMS Committee on Membership Recruitment and Retention. That's also the message of this month's special report, which begins with a letter from Doctor Kahkonen. Following her letter, this month's special report features a profile of the MSMS membership committee; an overview of the successful 1988 "Membership that Matters" campaign; a look at two new MSMS sections, one for graduates of foreign medical schools and one for young physicians; an examination of the value of AMA membership, presented by Frank B. Walker, MD, and Robert D. Burton, MD; an explanation and chart showing where your membership dues go; a complete list of all MSMS committees; a list of component medical societies and contacts; and finally, a list of whom to call at MSMS.

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Features

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Michael R. Kelly, chief of insurance marketing for this MSMS subsidiary, explains why physicians should take advantage of PSG services

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Organ donor campaign underway

MSMS, the MHA and the State Bar of Michigan join forces to increase public awareness of the need for organ and tissue donations — By David K. Fox

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Health Education Foundation

This non-profit charitable organization is working hard to promote healthy living in Michigan — By Chad B. Munger

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Practice Management

This third in a series of articles on practice management examines the benefits of offering employee pension plans — By Larry K. Winegar

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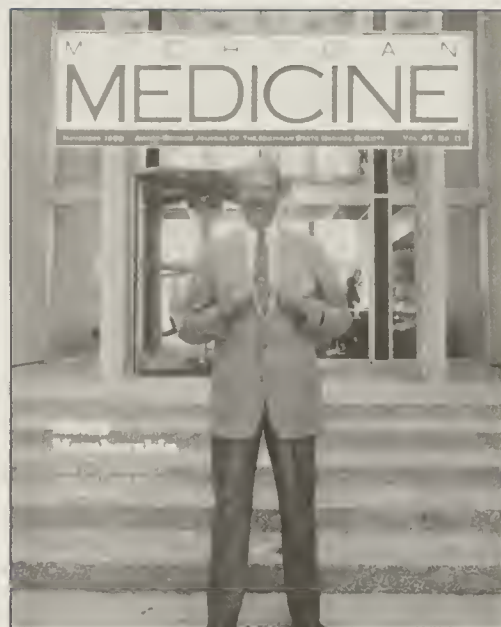
Board of Medicine actions

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Physician's File

This sixth in a series of reference reports for physicians addresses recent revisions of Michigan vital records forms to be used in 1989

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Departments

In my opinion

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In next month's issue of *Michigan Medicine*:
An examination of Harvard University's
Resource-Based Relative Value Scale.

Cover photo by: Patrick Yockey

Health care for prisoners is a societal obligation

By Carl F. Hammerstrom, MD

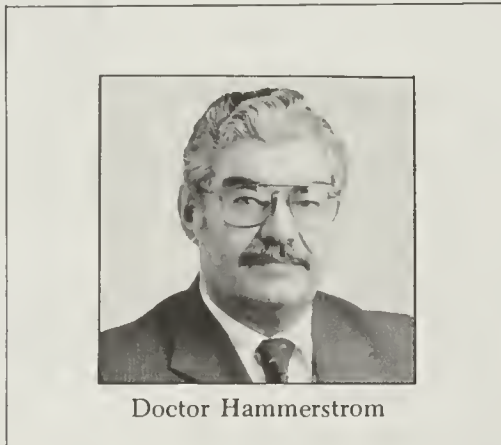
The current liability climate, low levels of available insurance, and reluctance of insurers to cover physicians contracting with the state to provide care to prisoners has made physicians wary of exposure to that risk.

In general, however, Michigan hospitals and physicians have responded well to requests to provide specialty care and care of an intensity greater than that provided on-site at prison health care facilities.

The Michigan Board of Correction's staff physicians are to be commended for their care of Michigan's prisoners.

Security and cost considerations have made it desirable to

Doctor Hammerstrom is a member of the MSMS Committee on Publications.



Doctor Hammerstrom

deliver as much of the medical care for prisoners as is possible in facilities located "on-site" at the prisons.

Duane Waters, MD, of Manistique, serves on the State Board of Corrections. He has monitored and worked to improve the quality of medical care available to prisoners in Michigan's correctional facilities. He has been in-

strumental in modernizing and increasing the care capabilities of these prison health care facilities.

Doctor Waters, on behalf of the Board of Corrections, approached State Senator Nick Smith (R-Addison), who sponsored Senate Bill 745. This bill calls for the amendment of the state law which provides immunity to all state employees, provided their actions do not constitute gross negligence or willful misconduct.

MSMS has supported this legislation, although as written it would only apply to care given in a prison-based health care facility. We have met with the Board of Corrections, and that Board is seemingly amenable to seeking to extend protection to care given to

Continued on page 710

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Light at the end of the tunnel for GFMSs

Two new measures now pending congressional action have given a big boost to the cause of graduates of foreign medical schools (GFMS). I refer to HR 3272 entitled, "The Fair Physician Licensure Reciprocity Standard Act of 1987," and HR 3241 entitled, "The Equal Opportunity for Medical Licensure and Reciprocity Act of 1987," sponsored by Congressmen Solarz and Bates, respectively.

All those who are familiar with the travails of graduates of foreign medical schools in America and the discrimination that their medical careers are being subjected to, cannot but appreciate the significance of these measures.

On the part of GFMSs and all those who have found cause with them, it is heartening to realize that there are still Americans, notably two congressmen above mentioned, who understand the realities of GFMSs' problems in America and who find, above all, the acts of discrimination GFMSs have of late suffered to be as revolting to conscience as they are repulsive to the tenets of American democratic tradition.

Viewed in the perspective of the GFMSs' struggle for fair treatment in the pursuit of the

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Continued on page 713



MSMS Membership

Now, more than ever before,
membership in organized
medicine is vitally important

Dear Colleague:

This is a trying time for our profession. However, through membership in organized medicine we can use our combined influence in the social, political and economic arenas. Our organization is truly democratic and is the only association that can represent the concerns of you and your patients.

MSMS policy is formed annually at the House of Delegates. The policies acted upon by the House are then referred to the Board of Directors or one of the 50 committees and task forces of MSMS. These committees range from the Committee on Aging, whose activities include examining the health status of older patients, to the Liaison Committee with the Michigan Physician Review Organization, which provides policy input to MPRO on medical and operational issues.

MSMS also has developed special sections to address the concerns of hospital staff physicians, graduates of foreign medical schools, young physicians, residents and students. (In-depth reports on the MSMS Graduates of Foreign Medical Schools Section and the MSMS Young Physicians Section, both new MSMS sections, can be found on page 684 and 687 respectively.) These sections have been created to address the needs of these groups and formulate plans to meet them.

The MSMS committee structure is very active, with most committees meeting four to six times per year to explore and debate issues important to you and your patients. (Information on MSMS committees can be found beginning on page 693.)

As part of the federation of medicine, MSMS also has 22 elected representatives to the American Medical Association's House of Delegates. This year MSMS is well represented on the Board of the AMA by Frank B. Walker, MD, MSMS board chairman, and on the Governing Council of the AMA's Hospital Medical Staff Section by Peter A. Duhamel, MD, who serves as secretary.

Many other MSMS members actively serve at the county level as officers and committee members to help make the county organizations effective and viable associations. Each of these individual organizations helps to make the federation of organized medicine work for **all** its members.

The only way we can continue to work successfully in all our endeavors is to increase our membership revenues. We can do this by convincing our colleagues of the benefits of being a member of organized medicine. We must show them that each of us has responsibilities and duties to our profession which can only be accomplished by organized medicine.

It is up to us to tell non-members of the advantages of membership and of the ways they can contribute to the cooperative activities which will be for the good of all physicians and the general public.

Organized medicine represents the majority's will for the betterment of our profession. It is only through active involvement of members in committees, regular association meetings, social activities, gatherings with peers and with the public that we can be recognized as leaders and spokesmen for our colleagues, our patients, and our profession.

MSMS also has many tangible benefits. But in the final analysis, MSMS is physicians like you and me willing to serve the profession—over and above paying dues, committed to making the organized medicine democracy work for us and our patients.

Sincerely,

Dorothy Kahkonen, MD

Dorothy Kahkonen, MD,
Chairman,
MSMS Committee on Membership
Recruitment and Retention

MSMS committee strives to make your membership matter

By Chad B. Munger

Membership has its privileges. Any of the 22 members of the MSMS Committee on Membership Recruitment and Retention would love to tell you all about them. After all, for this committee, membership is what MSMS is all about.

Being aware of the benefits provided by the Michigan State Medical Society is the first step to becoming an effective member and a good recruiter, says Dorothy Kahkonen, MD, committee chairman.

"Creating awareness of the MSMS role in the medical community is one of the Committee's primary goals," she says. "I think we need to make non-member physicians aware of what we do. Many people don't realize that you can't get things like seat belt legislation passed without physician support."

The Committee uses a number of methods to reach potential members, including phonathons in specific Michigan counties, direct mail solicitations, and individual non-member recruitment by physicians.

The Committee also combines forces with the AMA to recruit new members. The AMA provides MSMS with the names of physicians who will be moving into the state from other parts of the world. These people are then contacted by MSMS and the appropriate county medical society to encourage membership in all levels of organized medicine. Daily recruitment techniques are complemented by an annual recruitment drive.

The Committee's most recent campaign effort, entitled "Membership That Matters," took a somewhat new recruitment approach. The campaign, which resulted in 126 new members, emphasized the role of the physician in the recruitment process.

"The campaign was a well-coordinated effort," says Cathy O. Blight, MD, outgoing chairman of the Committee. "It just brought all the other programs we do into focus."

Physicians were asked to participate in the membership drive by directly soliciting non-members; by doing so, they gained some insight into the challenge of recruiting as well as the variety of services MSMS offers.

"I would have liked to have signed up a thousand new members," says Doctor Blight, "but that probably would have been unrealistic. Overall, the campaign went very well. It got a lot of physicians involved and aware of the many challenges of membership recruitment. I think, in a way, it made everyone more aware of membership and

its importance."

When not concentrating on a large recruitment drive or selling memberships over the phone, committee members can be found reorganizing their recruitment strategy or meeting with member groups to discuss their concerns. The Committee meets four or five times per year, which allows members from all over the state to gather and share their unique problems and create solutions to their problems. Projects like the Physician Outreach Program are fine tuned by the Committee.

Physicians of all ages, backgrounds and interests play vital roles as MSMS members. Of particular interest to the Committee are groups which are not always represented adequately in political positions, such as young physicians, women physicians, and graduates of foreign medical schools.

"MSMS is a natural platform for the special concerns of these groups," says Doctor Kahkonen. "Every individual in organized medicine encourages input from these physicians. While we are all in the motherhouse of medicine, it's important for physicians to have their own special area where they can voice their concerns."

While recruiting is an important part of the Committee's mission it is only part of it. Retention is the rest.

The benefits of being an MSMS member go a long way toward keeping physicians involved with MSMS. When it comes time to pay membership dues, however, doctors often re-evaluate what they have received from membership in MSMS. Commonly, people who choose to end their membership do so because they feel organized medicine has not adequately addressed their concerns, whether it is the malpractice issue, Blue Cross/Blue Shield reimbursement, or a specific piece of legislation. The Committee devotes a great amount of time to encouraging physician involvement with MSMS and emphasizing all the benefits MSMS provides to its members.

"The Committee's mission is so large that it cannot possibly accomplish it on its own," says Doctor Kahkonen. "As a member of MSMS you can do your part by spreading the word about membership in the federation of medicine and by supporting the efforts not only of this committee, but all MSMS committees."□

1988 Membership Campaign was a huge success

By Deborah Zannoth
MSMS Chief, Membership Development

The 1988 Membership Outreach Program, "Membership that Matters," was an extremely successful effort to attract new members to MSMS and to the county medical societies. The program resulted in 126 new members for organized medicine.

Much of the credit for the success of this campaign must go to Gilbert B. Bluhm, MD, immediate past president of the Wayne County Medical Society. Doctor Bluhm was the top recruiter, bringing in a total of 26 new members. For his efforts, Doctor Bluhm was awarded a wool camel blazer with a detachable MSMS lapel seal. (Pictured on cover and page 680.)

The Wayne County Medical Society captured the top prize in the county competition. Roger F. Mecum, WCMS executive director, received a crystal paperweight for the recruitment of 56 new members. Gabriel R. Pereira, MD, chairman of the MSMS Resident Physician Section, was awarded a wool navy blue blazer with the detachable MSMS lapel seal for recruiting 11 new members.

Physicians recruiting between five and nine new mem-

bers received a lightweight jacket with the MSMS seal. Those recruiting one to four new members received a monogrammed leather portfolio with the MSMS seal.

A total of 218 physicians participated in the campaign as recruiters and received a certificate of appreciation for their hard work. Results of recruiter efforts are detailed in the chart below.

The MSMS Committee on Membership Recruitment and Retention is extremely pleased with the 1988 recruitment campaign; plans are underway for a similar effort in 1989.

Looking back upon the success of the 1988 membership recruitment campaign, Cathy O. Blight, MD, then chairman of the Committee, said, "I am delighted with the efforts of all the recruiters and sincerely believe no one is better able to recruit new members than is a current member of MSMS, one who understands the benefits of belonging to organized medicine."

The MSMS Board of Directors sincerely appreciates the efforts of all the recruiters and looks forward to a successful campaign in 1989! □

Recruiter	County	Number of new members			
Gabriel Pereira, MD	Wayne	11	Karen D. Bortscht, MD	Wayne	1
Samir Yahia, MD	Wayne	8	A. Bradley Eisenbrey, MD	Wayne	1
Mark J. Brennan, MD	Oakland	5	Cyrus Farrehi, MD	Genesee	1
Hugh G. Deery, II, MD	N. Michigan	5	Robert F. Fawcett, MD	N. Michigan	1
Lorenz Kielhorn, MD	Jackson	5	James E. Fenton, MD	Bay	1
S.R. Nair, MD	Monroe	5	Stan Golec, MD	Wayne	1
Dawn E. Springer, MD	Ingham	5	H.L. Grover, MD	Genesee	1
Robert D. Allaben, MD	Wayne	4	Robert Hayashi, MD	Washtenaw	1
Edward G. Jankowski, MD	Wayne	3	William Heckman, MD	Oakland	1
E. James Potchen, MD	Ingham	3	Samuel Indenbaum, MD	Wayne	1
Marilyn B. Williams, MD	Wayne	3	Tama Martini, MD	Washtenaw	1
Cathy O. Blight, MD	Genesee	2	Appa Mukkamala, MD	Genesee	1
J. Carlos Borrego, MD	Wayne	2	David E. Ojeda, MD	Genesee	1
Nancy Couch, MD	Wayne	2	Robert Rosenbaum, MD	Genesee	1
Dorothy Kahkonen, MD	Wayne	2	Orlando Sison, MD	Wayne	1
Phillip Manno, MD	Wayne	2	Stanley R. Smith, MD	N. Michigan	1
Terrence Marcelle, MD	Calhoun	2	Richard A. Stone, MD	Macomb	1
Michael Mittell, MD	Ingham	2	S. Subramanian, MD	Livingston	1
Darrell Rosen, MD	Kent	2	Robert W. Tausher, MD	Genesee	1
Y.A. Siddiqui, MD	Shiawassee	2	Lucius C. Tripp, MD	Macomb	1
Hilary H. Timmis, MD	Oakland	2	Dale A. Wilson, MD	Genesee	1
Marilyn B. Williams, MD	Wayne	2	Louis A. Zako, MD	Wayne	1
			George Zureikat, MD	Genesee	1

MSMS establishes section for grads of foreign med schools

By Busharat Ahmad, MD,
GFMS Section Chairman

MSMS is a pioneer again. Over the years, MSMS has been in the forefront of physician efforts in such areas as Medicaid reimbursement, CME programs, publications and liability reform.

This time, MSMS is leading the nation in establishing the first-ever state-level section for foreign-trained graduates.

When the 1987 AMA House of Delegates denied a movement for a national-level Section, leaders of that movement (who happen to be Michigan physicians), came back to MSMS with a request for a state-level section.

Busharat Ahmad, MD, Marquette, chairman, Steering Committee for the GFMS Section, says it is necessary for foreign-trained physicians to have a Section because "we need a platform where we can sit down together and discuss our problems." He assessed the defeat of the national-level section as a win, in the sense that "we were able to educate a lot of people about GFMS problems."

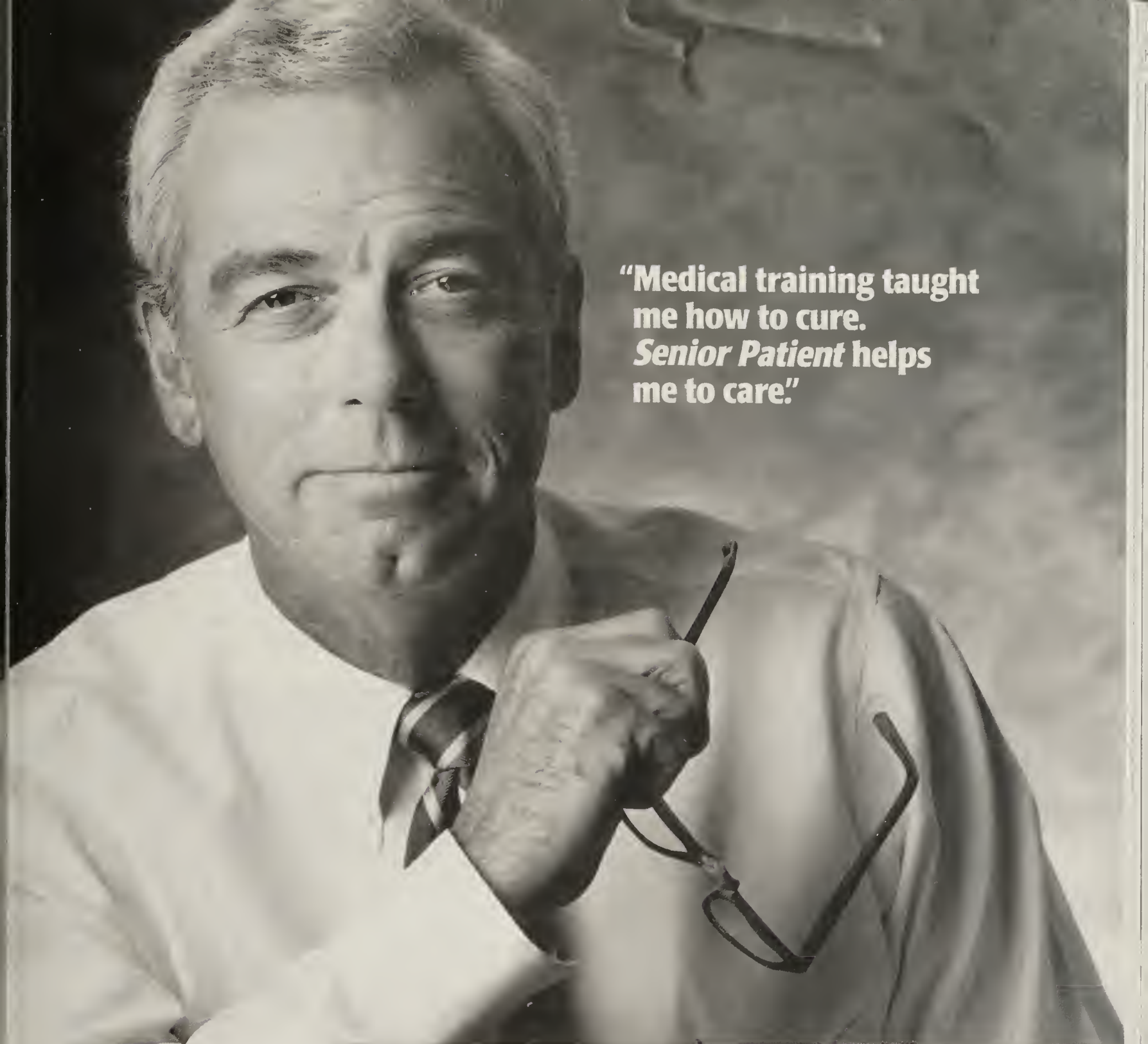
Continued on page 686



Busharat Ahmad, MD, chairman, Steering Committee for the MSMS Section for Graduates of Foreign Medical Schools, testified September 20 in favor of pending physician licensure rules changes. The changes, proposed by the Michigan Board of Medicine, would require all newly-graduated physicians, regardless of the location of their schooling, to complete two years of residency training. Current rules require one year for US- and Canadian-trained physicians, and three years for foreign-trained physicians. Several other persons testified at the hearing, all in favor of the rules changes.



Over an August dinner at MSMS headquarters, leaders of physician nationality groups in Michigan became acquainted. The dinner was held by the Steering Committee for the MSMS Section for Graduates of Foreign Medical Schools.

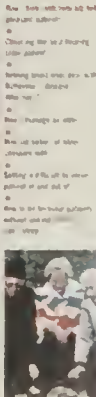


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GFMS SECTION/Continued

The MSMS House of Delegates approved the new MSMS Section on first reading at the 1988 annual meeting May 1. Speaker of the House Gerald H. Mandell, MD, noted, "It's possible that what we have done today will set the format for physicians nationally."

Since approval of the Section on first reading in May, the Steering Committee for the Section has published another in its series of quarterly newsletters, and has held a dinner for leaders of physician nationality groups in Michigan.

The purpose of the dinner was to tell the physician leaders about MSMS activities on their behalf, and to allow them to express their insights about GFMS concerns.

The nationality leaders praised MSMS and its leadership for their commitment.

"We have problems all the way from our entry into training to the point we enter private practice," said Doctor Evangelista. "I think this Section really will serve as a forum."

Steering Committee members now are busy planning

for the Section's organizational meeting, March 17-18, 1989, at the Ritz Carlton Hotel, Dearborn.

Delegates will come from hospitals across the state to elect officers and to prepare resolutions to send to the MSMS House of Delegates 1989 annual meeting. Any interested physicians may attend to participate in the discussions.

Doctor Ahmad calls on his fellow graduates of foreign medical schools to participate in the formation of the new MSMS Section.

"We have come a long way, from nowhere to forming a Section," he says. "But the Section will be successful only if you and your colleagues participate."

Members of the Steering Committee for the Section include: Waheed Akbar, MD; Jaime Aragonés, MD; Stella Evangelista, MD; Mujtaba Husain, MD; David Jaimovich, MD; Byung S. Lee, MD; Phillip J. Manno, MD; Appa Rao Mukkamala, MD; Dhanwada S. Rao, MD; Krishna K. Sawhney, MD; Virgilio F. Vasquez, MD; G. Wollschlaeger, MD; and Samir R. Yahia, MD.



David Jaimovich, MD, Kalamazoo, left, graduate of a Guadalajara medical school, and Jayant Shah, MD, president of the Michigan Association of Physicians from India, share common concerns at the August dinner. Among the subjects the physician nationality leaders raised were residency training requirements for physician licensure in Michigan, graduates of foreign medical schools' representation in organized medicine, and hospitals' requirements for test grades to determine residency eligibility.



Koreans J.Y. Lee, MD, Marine City, left facing camera, and J.K. Rhee, MD, Bloomfield Hills, center, joined fellow physician nationality leaders at the reception preceding the dinner. They heard presentations by MSMS leaders on current state society activities and priorities, and enjoyed a discussion of the purposes and goals of the new MSMS Section for Graduates of Foreign Medical Schools.

New MSMS section addresses concerns of young physicians

By Richard A. Stone, MD
Chairman, MSMS Young Physicians Section

Recognizing young physicians as a sizable and growing constituency of organized medicine, the 1988 MSMS House of Delegates approved the establishment of a Young Physicians Section at its meeting last April.

The purpose of the new Section is to encourage young physicians to become actively involved in organized medicine, to better address their challenges. It is one of 21 such state medical society sections formed to serve the same basic purposes.

At the 1985 Annual Meeting of the AMA House of Delegates, fewer than two percent of all delegates were physicians under the age of 40, and only one delegate under age 40 was a practicing physician. Over 44 percent of the young physicians surveyed by the AMA in 1986 expressed interest in becoming more active in organized medicine. Of those, 66 percent preferred local involvement, 44 percent desired state-level participation, and 22 percent cited interest in national level activities.

Who can participate in the Section

Based upon AMA criteria, membership in the MSMS Section is open to all MSMS members under the age of 40 or those professionally employed for less than five years. Professional employment excludes postgraduate training and obligated military service.

A delegate and alternate delegate (young physicians who are voting members of MSMS) will be appointed by the president of each of the 58 county medical societies. Any other MSMS young physician may attend and observe during the Annual Meeting, but will not have voting privileges.

How the Section was developed

Over one year ago, 18 young physicians were recommended to serve on the MSMS Young Physicians Task Force. Sixteen young physicians accepted this appointment. There are now 28 members of the task force, representing nine counties.

The goal of the Task Force, which will terminate in March 1989, is to establish the new Section. Another goal is to encourage more young physicians to become involved in organized medicine by serving on MSMS committees. Through Task Force efforts there now are 19 more young physician members participating on MSMS committees.

Yet another goal is to educate young physicians on topics relating to financial, medical practice management and political action, to assist them in establishing themselves in their medical careers. Consequently, the Task Force developed a one-day program tailored for young physicians and senior residents, which was held last month at the Hyatt Regency Dearborn.

The program featured carefully selected instructors with a good knowledge of the medical economic environment in Michigan. The featured luncheon speaker was State Representative James A. Kosteva, who discussed "The Political Future for Young Physicians in Michigan." Workshop topics were: How to evaluate a practice opportunity; the risks and rewards of various alternative healthcare finance systems; how to evaluate contracts, malpractice coverage and protect your assets; how to select your professional advisor and tax planning; and how to develop a beneficial retirement plan.

At every AMA-Young Physicians Section Annual Meeting and AMA-Young Physicians Section Interim Meeting since 1986, there has been at least one delegate to represent young physicians from Michigan.

At last year's MSMS House of Delegates, there were sixteen young physician delegates who caucused to review pertinent resolutions prior to testifying before the House of Delegates. Since they were still a Task Force, the group submitted their resolutions through their respective county medical societies.

Some of the issues which were raised by the young physicians included: Establishment of a committee to review complaints against "expert" witnesses; referral center for hospital incentives; mandatory AIDS testing; abolishment of "certificate of need"; and per-case assignment of Medicare payment for the financially needy.

As chairman of the MSMS Young Physicians Section, I strongly encourage MSMS young physician members to attend the First Annual MSMS Young Physicians Section Meeting March 2 at the Sheraton Hotel, Lansing. More details, including registration information, appear on the next page.

For more information concerning the Young Physician Section activities, contact Linda Munson, MSMS-YPS staff, at MSMS headquarters.

Continued on next page

YOUNG PHYSICIANS/Continued



Young physician delegates caucused at the 1988 MSMS House of Delegates to review pertinent resolutions prior to testifying before the House. In the forefront are Richard A. Stone, MD, chairman of the MSMS Young Physicians Section (standing), Carl A. Gagliardi, MD, and Cathy O. Blight, MD.

Event: First Annual MSMS Young Physicians Section Meeting
Date: Thursday, March 2, 1989
Time: 9:00 AM - 5:00 PM
Location: Lansing, Sheraton Inn

Young physicians represent a sizable and growing constituency of organized medicine. At the 1988 MSMS House of Delegates Meeting, the House approved the establishment of a MSMS Young Physicians Section (MSMS-YPS). Currently, 21 state medical associations have Young Physicians Sections.

Purpose of Meeting: To encourage young physicians to become actively involved in organized medicine.

Who Should Attend: Membership to the MSMS-YPS is open to all MSMS members under the age of 40 or professionally employed for less than five years. We are asking each county society president to appoint a delegate and alternate delegate (MSMS young physician member) by December 1st! **Contact your county medical society president for your name to be submitted for consideration as appointment for the delegate or alternate delegate to represent**

the young physicians from your county. Any other MSMS young physician members may also attend and observe during the Annual Meeting, but will not have voting privileges.

Agenda Highlights: On March 2, resolutions will be introduced, since like other special constituencies within organized medicine, young physicians possess a unique set of needs and concerns. Also, elections will be conducted for a Governing Council, which shall meet at least twice yearly under the direction of the Chairman. The Governing Council shall consist of the elected officers and delegates, as well as two at-large members appointed by the Chairman. There will also be a featured luncheon speaker, to be announced at a later date.

Registration: The \$40 registration fee includes continental breakfast; luncheon and YPS Handbook. Overnight accommodations have been reserved for a February 1st cutoff at \$63 Sgl./\$73 Dbl. After February 1st, overnight accommodations will be on an availability basis.

For further information, contact Linda Munson, MSMS-YPS staff at MSMS headquarters (517) 337-1351.



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AMA Membership: It's a question of dollars and sense

By Frank B. Walker, MD
and Robert D. Burton, MD



Doctor Walker



Doctor Burton

Throughout our medical careers, we have heard our colleagues express concern over the cost of membership dues. Frankly, those are feelings we have a hard time understanding, not because the cost of dues isn't a concern to us, but because we believe our colleagues have been wrongly focusing on considerations of price rather than value.

Economists frequently use the term "cost-benefit ratio" when talking about the price of an item or service in relation to its value. That's the way medical professionals should be looking at membership dues.

We truly believe AMA membership could withstand any cost-benefit analysis, with the benefits far exceeding the cost. We're not referring merely to the tangible benefits of membership, although they are certainly numerous and diverse. They include publications such as *JAMA*, *AM News*, educational seminars and workshops, insurance programs, and much more. All are significant benefits provided by the AMA.

We believe the real value of membership lies in other areas— areas not so easily defined.

Doctor Walker is a member of the AMA Board of Trustees and is chairman of the MSMS Board of Directors. Doctor Burton is chairman of the Michigan Delegation to the AMA and is Speaker of the MSMS House of Delegates.

To assess the true value of membership, you should ask yourself these questions:

1.) What is it worth to have your rights and interests represented in your local and state legislatures as well as in Congress?

2.) What is it worth to have your colleagues, rather than the government, define and monitor the standards for medical training and medical care?

3.) What is it worth to have a representative forum in which you, along with your colleagues from across the country, can raise and argue issues?

4.) What is it worth to have a strong, unified voice of American medicine? This would enable one of your colleagues testifying before the US Congress to say, "Yes, I represent all the physicians in this country."

Every member of your Michigan Delegation to the AMA welcomes your opinions and your constructive criticism. We constantly strive to carry your concerns and ideas forward to the national level for discussion and action.

If you do not join your medical colleagues, and fail to pay your AMA share, you forfeit a valuable opportunity—the chance to have a positive influence on medical care for your patients and on the future direction of your medical practice.

In the final analysis, you must decide whether you can afford to join the AMA. Our question to you is: Can you afford not to? ☐

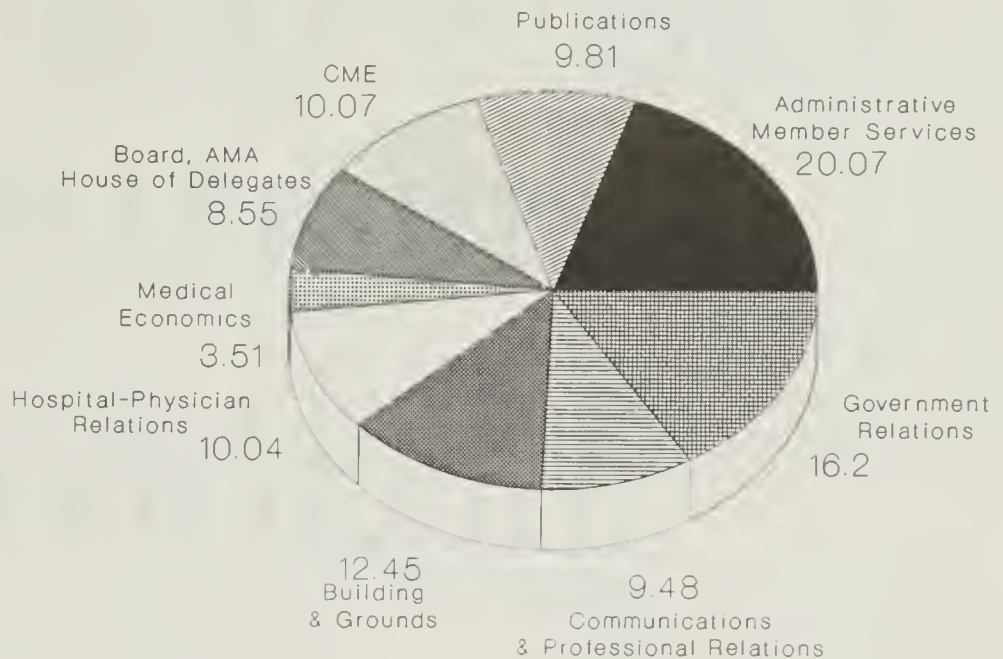
Where your dues go

Membership fees for your state medical society, which are \$350 for 1989, are parceled out prior to the MSMS fiscal year, which begins December 1. Making the decisions are members of the Finance Committee of the MSMS Board of Directors, chaired by B. David Wilson, MD.

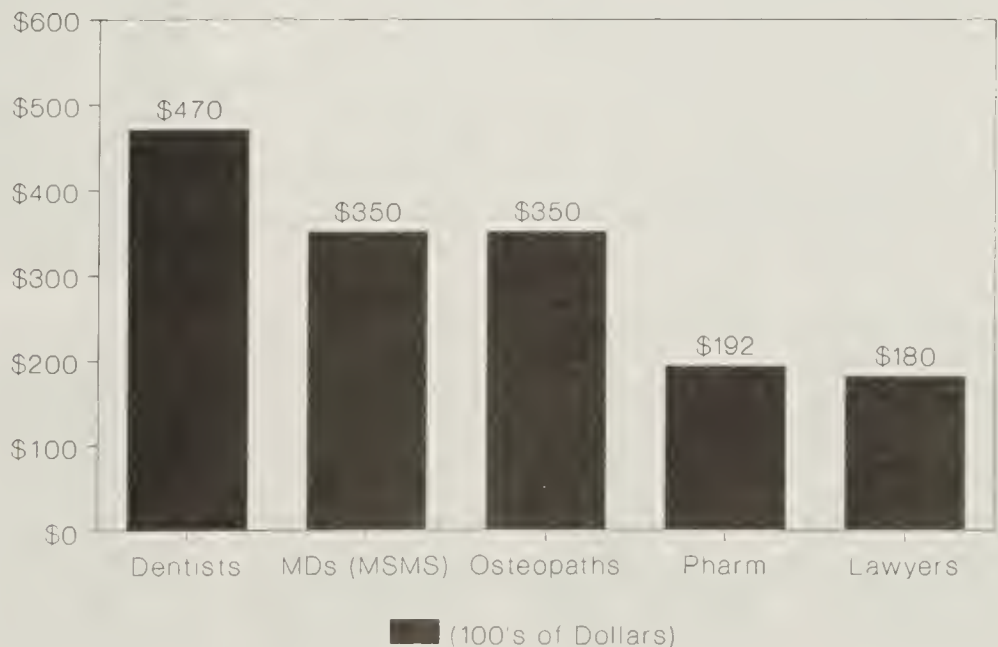
The Finance Committee acts on the recommendations of the MSMS Budget subcommittee to the Finance Committee and spends many hours during the fall months analyzing every projected expense and revenue item. They obtain final approval for the budget from the MSMS Board of Directors.

The pie chart at right illustrates the distribution of MSMS income from dues and other sources to MSMS program areas. It is published to give MSMS members a clearer idea of how MSMS revenues are spent.

The chart at the bottom of the page shows what other Michigan professionals pay in dues and how they compare to MSMS dues. □



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MSMS committees address many issues

The 40-plus MSMS committees and task forces provide a platform for addressing issues ranging from AIDS to ATVs. To effectively address such a wide range of issues, MSMS committees rely heavily upon member input. MSMS encourages as many different physicians as possible to participate in the committee system, especially those people from groups like young physicians and graduates of foreign medical schools who may, at times, be under-represented in the medical/political community.

Committee appointments are awarded annually at the MSMS Mid-

summer Board of Directors Meeting held in July. Members are selected from a pool of applicants who have been nominated by current committee members, special section leaders and leaders of county medical societies. Committee appointments are two-year terms, with new appointments taking place annually.

The first step toward obtaining a position, and the most difficult, is determining which committee (or committees) interests you most. A complete list of MSMS committees and task forces begins on this page. Each committee listing includes a

brief statement of goals.

Members interested in serving on a committee must receive a recommendation. Simply contact a current committee member, special section leader, MSMS Board member, or your county medical society and request a recommendation. Each January MSMS sends a request for recommendations to all county medical societies. So now is a good time to start thinking about what committee you would like to join.

For more information on any of the MSMS committees, contact Katie Brewbaker at MSMS. □

COMMITTEE ON AGING

This Committee provides physicians with an overview of the medical, social, and psychological needs of the aged patient. Activities include examining the health status of the older patient, advocating preventative medicine programs, discussing Medicare financing, and exploring long term care options for the elderly. The Committee works with many community organizations and the State Office of Services for the Aging.

James G. O'Brien, MD
East Lansing
Chairman

Mrs. Pat Allen, Battle Creek
Harvey M. Andre, MD, Grand Rapids
Frank S. Blumenthal, MD, Detroit
Bernard Chodorkoff, MD, Drayton Plains
Diane A. Culik, MD, Grosse Pte. Farms
Phillip M. Green, MD, Kalamazoo

Kenneth B. Herrington, MD, Bad Axe
J. Christopher Hough, MD, Midland
Richard A. Knecht, MD, Petoskey
Daniel E. Leb, MD, Bloomfield Hills
Brooker L. Masters, MD, Fremont
Loren L. Russcher, MD, Kalamazoo
Rakesh N. Saxena, MD, Alma
Ashok R. Sonnad, MD, Vestaburg
Margaret S. Terpenning, MD, Ann Arbor
Robert J. Toteff, MD, Pleasant Ridge
Russell E. Holmes, MD, Consultant, Lansing
Thomas J. Northey, Consultant, Lansing
John Peterson, PhD, Consultant, Lansing
James R. Tarrant, Consultant, East Lansing
F. B. "Tom" Plasman, Staff

TASK FORCE ON AIDS EDUCATION

This Task Force develops strategies for educating physicians about AIDS and coordinates MSMS efforts in physician and public

education with those of the Michigan Department of Public Health.

Frederick W. Bryant, MD
Royal Oak
Chairman

E. Joseph Alberding, MD, Portage
David S. Davenport, MD, Kalamazoo
William E. Dougan, MD, Detroit
John F. Fennessey, MD, Grosse Pointe
Evelyn J. Fisher, MD, Detroit
Douglas A. Mack, MD, Grand Rapids
David B. Martin, MD, Traverse City
David R. Rovner, MD, East Lansing
Lawrence R. Crane, MD, Consultant, Detroit
Mary Anne Ford, Staff

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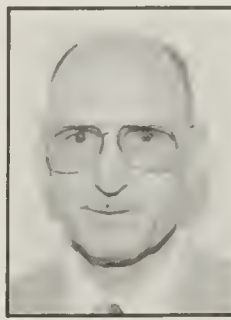
Addy



Adelman



Ahmad



Aiken



Barry



Bluhm

SPECIAL REPORT

MSMS COMMITTEES/Continued

LIAISON COMMITTEE WITH MICHIGAN MEDICAL ARBITRATION SYSTEM

This Committee serves as a liaison between MSMS and the Michigan Medical Arbitration System and works to promote the use of arbitration in Michigan.

Rhoda M. Powsner, MD
Dearborn
Chairman

John W. Hall, MD, Petoskey
Charles N. Inniss, MD, Detroit
Thomas A. Kwyer, MD, Dearborn
David W. Learned, MD, Ann Arbor
Ray H. Littleton, MD, West Bloomfield
Gerald H. Mandell, MD, Detroit
Samuel M. McMahon, MD, Lansing
Mary Anne Ford, Staff

COMMITTEE ON AWARDS

This Committee supervises the MSMS award program and makes recommendations to the Board of Directors.

Billy Ben Baumann, MD
Pontiac
Chairman

Henry M. Domzalski, MD, Detroit
Thomas C. Payne, MD, East Lansing
Katie Brewbaker, Staff

COMMITTEE ON BIOETHICS

This Committee considers questions about scientific, medical, moral ethical and political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and, therefore, MSMS.

Howard A. Brody, MD
East Lansing
Chairman

Isak O. Berker, MD, Lapeer
Frederick W. Bryant, MD, Royal Oak
John R. Caldwell, MD, Birmingham
Mrs. Betty Drew, Bloomfield Hills
Jay S. Finch, MD, Ann Arbor
Reginald W. Harnett, MD, Taylor
John V. Hartline, MD, Kalamazoo
Francis Horvath, MD, Lansing

Evan J. Reinders, MD, Muskegon
Charles A. Thompson, MD, Flint
Kornelius Van Goor, MD, Grand Rapids
William B. Weil, MD, East Lansing
Peter A. Levine, Consultant, Flint
Sherry N. Wellman, Staff

LIAISON COMMITTEE WITH BLUE CROSS BLUE SHIELD OF MICHIGAN

This Liaison Committee serves as a communication link to assist individual physicians in obtaining information concerning Blue Cross Blue Shield of Michigan's policies and procedures and provides input to aid in the resolution of problems which may arise. The Committee also considers and provides input on major policy and professional issues related to BCBSM.

Susan E. Adelman, MD
Detroit
Chairman

Robert W. Black, MD, Detroit
Gerald F. Conway, MD, Royal Oak
Donald K. Crandall, MD, Muskegon
David A. Detrisac, MD, East Lansing
Henry M. Domzalski, MD, Detroit
William B. Jensen, Jr., MD, Grand Rapids
Richard L. Rapport, MD, Flint
Arthur A. Ulmer, MD, Grosse Pointe Shores

BOARD OF MANAGERS

The Board of Managers oversees the management of the Capital Reserve Fund, the Creative Reserve Fund and the management of MSMS buildings and grounds.

Billy Ben Baumann, MD
Pontiac
Chairman

Justin L. Slight, MD, Lansing
Timothy M. Talbott, MD, Grand Rapids
Arthur A. Ulmer, MD, Grosse Pointe Shores
Fred W. Whitehouse, MD, Detroit
B. David Wilson, MD, Kalamazoo
Richard M. Campau, Staff

ADVISORY COMMITTEE ON COMMUNICATIONS AND PROFESSIONAL RELATIONS

This Committee develops and oversees all public relations and public service activities. It

provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

Henry M. Domzalski, MD
Detroit
Chairman

Robert C. Arends, MD, Birmingham
Gilbert B. Bluhm, MD, Southfield
Frederick B. Brown, MD, Muskegon
Juan C. A. Carioni, MD, Troy
Mrs. Nancy Crandall, Muskegon
Charles D. Bukrey, MD, Grand Rapids
Robert L. Cross, MD, Flushing
Don G. Davis, MD, East Lansing
Clyde R. Flory, MD, Lansing
Reed K. Freidinger, MD, Charlevoix
George C. Hill, MD, Ferndale
Raymond R. Komray, MD, Muskegon
Fred E. Patterson, MD, Jackson
B. L. Pederson, MD, Bay City
M. Gary Robertson, MD, Grand Haven
Jerry H. Rosenberg, MD, Southfield
Sherry N. Wellman, Staff

COMMITTEE ON CONSTITUTION AND BYLAWS

This Standing Committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meeting.

James E. McGillicuddy, MD
Lansing
Chairman

Robert H. Evans, MD, Sturgis
Jack D. Gift, MD, Jackson
Thomas F. Higby, MD, Fowlerville
John H. McLaughlin, MD, Birmingham
Eber B. Sherman, MD, Eaton Rapids
William E. Madigan, ex officio, East Lansing
Richard D. Weber, Consultant, Detroit
Vada L. Davis, Staff

COMMITTEE ON CME ACCREDITATION

This Committee assures that quality CME activities are available to Michigan physicians through review evaluation and accreditation of Category I continuing medical education providers in the state.



Brody



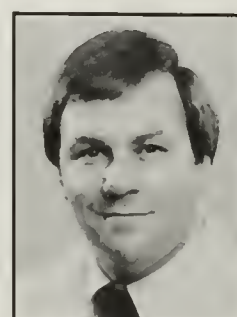
Bryant



Burton



Domzalski



Donn



Fenton

SPECIAL REPORT

Donald J. Aiken, MD **Okemos** **Chairman**

Gail E. Bank, PhD, Detroit
Ralph L. Brandt, MD, Ann Arbor
James C. Breneman, MD, Galesburg
Allen D. Damschroder, MD, Petoskey
Ernest M. Hammel, PhD, Rochester
Roland G. Hiss, MD, Ann Arbor
Van O. Keeler, MD, Kalamazoo
Mark D. Kolins, MD, Grosse Pointe Farms
Samuel M. McMahon, MD, Lansing
Bryant W. Pierce, MD, Grand Rapids
Robert K. Richards, PhD, Grand Rapids
Victor V. Rozas, MD, Alma
Joseph A. Sentkeresty, MD, Grand Rapids
Robert L. Tupper, MD, Grand Rapids
W. Donald Weston, MD, East Lansing
Richard F. Willis, MD, Alpena
Ralph M. Wynn, MD, Pontiac
Charles L. Zeller, MD, Kalamazoo
Thomas J. DeKornfeld, MD, Consultant, Lansing
Katie Brewbaker, Staff

COMMITTEE ON CME **PROGRAMMING**

This Committee develops, conducts, and supervises Category I programs in Michigan to serve the continuing medical education needs and interests of physicians. It also is empowered to jointly sponsor programs which meet the CME criteria for Category I.

David R. Rovner, MD **East Lansing** **Chairman**

Michael J. Giacalone, Jr., MD,
Vice Chairman, Grand Blanc
John R. Addy, MD, Lansing
Rudi Ansbacher, MD, Ann Arbor
Frederick W. Bryant, MD, Royal Oak
Richard E. Dean, MD, East Lansing
Bruce R. Deschere, MD, Pontiac
John W. Dircks, MD, Kalamazoo
Clyde R. Flory, MD, Lansing
Perry W. Greene, Jr., MD, Grand Rapids
Michael Iacobellis, MD, Allen Park
Terry Kinzel, MD, Houghton
Steven E. Minnick, MD, Detroit
Samir M. Ragheb, MD, Warren
Shirley Robertson, MD, Mason
George L. Royer, MD, Kalamazoo
Joan C. Stryker, MD, Detroit
James R. Tarrant, Consultant, East Lansing
Sherry L. Fent, Staff

LIAISON COMMITTEE WITH **CORPORATE MEDICAL** **DIRECTORS**

This Liaison Committee meets with medical directors of corporations to discuss common interests and recommend appropriate courses of action.

Richard H. Gascoigne, MD **Adrian** **Chairman**

Lionel E. Dorfman, MD, Battle Creek
David W. Hills, MD, Benton Harbor
David Jacknow, MD, Bloomfield Hills
Sanganur V. Mahadevan, MD, Allen Park
Steven E. Newman, MD, Southfield
Robert T. Nolta, MD, Warren
John H. Triebwasser, MD, Dearborn
R. J. Van Valkenburg, MD, Battle Creek
Clinton Ward Wilson, MD, Benton Harbor

STEERING COMMITTEE TO **DEVELOP A GRADUATES** **OF FOREIGN MEDICAL** **SCHOOLS SECTION**

This Steering Committee pursues the development of a GFMS Section to the MSMS House of Delegates and helps network graduates of foreign medical schools into the democratic process of MSMS.

Busharat Ahmad, MD **Marquette** **Chairman**

Waheed Akbar, MD, Saginaw
Jaime V. Aragones, MD, Rochester
Stella S. Evangelista, MD, Livonia
Mujtaba Husain, MD, Detroit
David G. Jaimovich, MD, Kalamazoo
Byung S. Lee, MD, Troy
Phillip J. Manno, MD, Dearborn
Appa Rao Mukkamala, MD, Flint
Robert E. Paxton, MD, Fremont
Dhanwada S. Rao, MD, Detroit
Krishna K. Sawhney, MD, Farmington Hills
V. F. Vasquez, MD, Muskegon
G. Wollschlaeger, MD, Birmingham
Samir R. Yahia, MD, Detroit
Judith Marr, Staff

ADVISORY COMMITTEE ON **HEALTH CARE POLICY**

This Committee recommends MSMS policy on health planning. It encourages physician involvement in state health planning activities, and in state health policy activities.

Fred E. Patterson, MD **Jackson** **Chairman**

Donald C. Barkel, MD, Royal Oak
Robert B. Carbeck, MD, Ann Arbor
Thomas F. Curtin, MD, East Jordan
James R. Dolan, MD, Kalamazoo
George R. Gerber, MD, Detroit
Denise G. K. Gray, MD, Detroit
John V. Hartline, MD, Kalamazoo
Terrell K. Hebert, MD, Grand Haven
D. Bonta Hiscoe, MD, East Lansing
Samuel D. Indenbaum, MD, Birmingham
Martin F. Jones, MD, Lansing
Steven E. Newman, MD, Southfield
Harold Perry, MD, Detroit
William E. Powers, MD, Detroit
Kenneth J. Ray, MD, Trenton
Marguerite R. Shearer, MD, Dexter
Donald C. Smith, MD, Ann Arbor
Robert M. Williams, MD, Traverse City
Mary Anne Ford, Staff

STEERING COMMITTEE ON **PROGRAM TO ASSIST** **IMPAIRED PHYSICIANS**

This Steering Committee provides assistance through its Medical Director and a statewide network of volunteer physicians to physicians who have problems related to emotional illness, alcoholism, or drug abuse. Education toward prevention, case finding, and intervention are major components of the program.

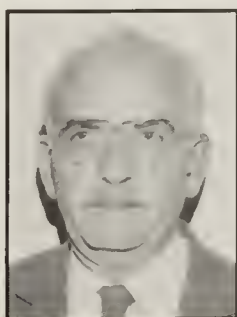
James L. Fenton, MD **Bay City** **Chairman**

Norman J. Bolton, MD, Detroit
Michael Boyle, DO, West Bloomfield
Sander J. Breiner, MD, Birmingham
Thomas A. Bruce, MD, Battle Creek
James P. Gallagher, MD, Allen Park
Thomas L. Haynes, MD, Grand Rapids
Robert H. Hydrick, MD, Grand Rapids
Mrs. Beverly Jensen, Grand Rapids
William H. Kaufman, MD, Allen Park

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Gascoigne



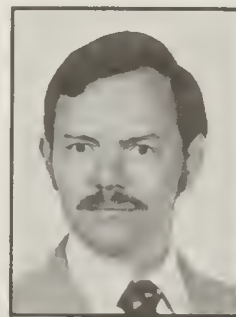
Greene



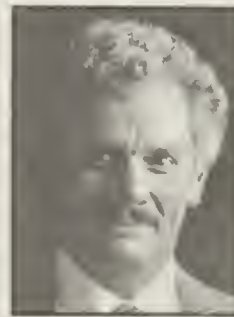
Jonas



Kahkonen



Lorenz



Mack

SPECIAL REPORT

MSMS COMMITTEES/Continued

Bobbe J. Kelley, DO, W. Bloomfield
William J. Kube, MD, Kalamazoo
Douglas W. MacDonald, MD, Oxford
Mrs. Cathie Martin, Traverse City
Joyce W. Mason, MD, Ann Arbor
Stephen C. Mason, III, MD, Ann Arbor
Richard A. Morin, MD, Ann Arbor
Robert Niccolini, MD, Detroit
John T. O'Connor, DO, Lansing
Gerald A. Sieggreen, MD, Saginaw
Justin L. Sleight, MD, Lansing
Robert S. Underhill, MD, Bloomfield Hills
Gerald A. Vander Voord, MD, East Lansing
Max W. Warren, MD, Southfield
Katie Brewbaker, Staff

JUDICIAL COMMISSION

The Commission has sole jurisdiction over matters of ethics, mediation, grievance, and discipline of MSMS members. It has authority to make binding interpretations of the MSMS Constitution and Bylaws and of component society bylaws, as well as rules and regulations governing such matters.

George W. Morley, MD
Ann Arbor
Chairman

Krishna K. Sawhney, MD, Vice Chairman,
Farmington Hills
John F. Fennessey, MD, Grosse Pointe
Edwin H. Gullekson, MD, Flint
John H. McLaughlin, MD, Birmingham
Joseph L. Ponka, MD, West Bloomfield
John C. Rienstra, MD, Grand Rapids
Richard D. Weber, Consultant, Detroit
Katie Brewbaker, Staff

COMMITTEE ON MATERNAL AND PERINATAL HEALTH

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal and perinatal health to discuss mutual problems and share ideas. It works in close cooperation with the state agencies and medical specialty organizations.

Robert P. Lorenz, MD
Royal Oak
Chairman

John R. Addy, MD, Lansing
Silvio Aladjem, MD, Kalamazoo

Rudi Ansbacher, MD, Ann Arbor
Sidney Bottoms, MD, Detroit
C. Arch Brown, MD, Flint
David R. Calver, MD, Bloomfield Hills
Ralph A. Cram, MD, Albion
Preston V. Dilts, MD, Ann Arbor
Steven M. Donn, MD, Ann Arbor
William E. Dougan, MD, Detroit
Robert W. Dustin, MD, Dearborn
Gerhard C. Endler, MD, Grosse Pointe Woods
John D. Fachnie, MD, Birmingham
Alan M. Gardner, MD, Ann Arbor
James W. Gell, MD, Bloomfield Hills
John V. Hartline, MD, Kalamazoo
Robert H. Hayashi, MD, Ann Arbor
Lloyd A. Kammeraad, MD, Grand Rapids
Douglas G. Kinne, MD, Petoskey
Mary J. Kokosky, MD, Dearborn
James G. Kornmesser, MD, Novi
Mrs. Pat Krapohl, Jackson
Chang Yoon Lee, MD, Flint
Francis A. Locke, MD, Adrian
M. Jeffrey Maisels, MD, Royal Oak
Federico G. Mariona, MD, Dearborn
Joseph P. Metz, MD, Flint
Joseph S. Moore, MD, Grand Rapids
Bernhardt L. Pederson, MD, Bay City
Jose A. Peralta, MD, Rochester
Roger W. Postmus, MD, Ypsilanti
Donald F. Silver, MD, Franklin
Robert J. Sokol, MD, Detroit
Errol I. Soskolne, MD, Ann Arbor
Arthur A. Ulmer, MD, Grosse Pointe Shores
Paul T. Von Oeyen, MD, Royal Oak
Earl R. Williams, MD, Tustin
George H. Baker, MD, Consultant, Lansing
Mary M. Conklin, RN, Consultant, Lansing
George W. Russian, DO, Consultant, Okemos
Charles H. Sander, MD, Consultant, East Lansing
Mary A. Scoblic, RN, Consultant, Lansing
Richard Yerian, DO, Consultant, Lansing
Katie Brewbaker, Staff

ADVISORY COMMITTEE TO SECTION ON MEDICAL ECONOMICS

This Advisory Committee assists the Section in setting priorities, studies current health care financing, makes specific recommendations concerning futures financing mechanisms, and

develops an understanding of traditional insurance companies, emerging alternative financing and health delivery systems.

Gilbert B. Bluhm, MD
Southfield
Chairman

Asir U. Ahmad, MD, Pontiac
Jack L. Barry, MD, Saginaw
Joseph J. Berke, MD, Detroit
M. Joseph Bowler, MD, Kalamazoo
Frederick B. Brown, MD, Muskegon
Robert B. Carbeck, MD, Ann Arbor
Frank E. Check, Jr., MD, Detroit
Floyd G. Goodman, MD, East Lansing
Denise G. K. Gray, MD, Detroit
Harvey W. Halberstadt, MD, Birmingham
Edward G. Jankowski, MD, Warren
Margaret E. Jones, MD, East Lansing
Daya P. Joshi, MD, Livonia
Stanley H. Levy, MD, Detroit
Max L. Lichter, MD, Farmington Hills
Thomas S. Marks, MD, Grand Rapids
Appa Rao Mukkamala, MD, Flint
Mrs. Shirley Prust, Franklin
Richard L. Rapport, MD, Flint
Edward J. Rutkowski, MD, Traverse City
Kenneth G. Schooff, MD, Detroit
Robert N. Shannon, MD, Ludington
Floyd S. Tukel, MD, Dearborn
Frederick W. Van Duyne, MD, Flint

TASK FORCE ON RURAL HEALTH CARE

This Task Force gathers information on the increasing challenges of change occurring in rural health care and helps physicians make the necessary practice changes so that they may continue to provide quality health care to rural Michigan residents.

Frederick W. Bryant, MD
Royal Oak
Chairman

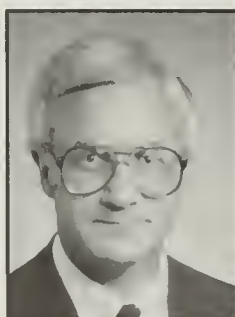
David H. Gilbert, MD, Calumet
Kenneth B. Herrington, MD, Bad Axe
Tom M. Johnson, MD, East Lansing
Michael J. Parks, MD, South Haven
Robert E. Paxton, MD, Fremont
Frank L. Pettinga, MD, Muskegon
Louis E. Sanford, MD, Belding
Devendra K. Sharma, MD, Tawas City
F. B. "Tom" Plasman, Staff



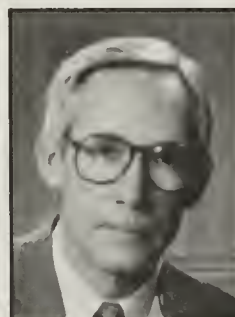
McMahon



Minkow



O'Brien



Packer



Patterson



Paxton

SPECIAL REPORT

MEDICAID LIAISON COMMITTEE

This Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

Cecil R. Jonas, MD
Southfield
Chairman

Janet K. Baum, MD, Ann Arbor
Abraham Becker, MD, Detroit
Rolland E. Bethards, MD, Lansing
Thomas M. Flake, MD, West Bloomfield
William E. Hill, MD, Pontiac
Harm Kraai, MD, Pontiac
Robert L. Leaser, MD, Charlotte
Michael J. Parks, MD, South Haven
Thomas C. Payne, MD, East Lansing
Allen F. Turcke, MD, Flint
Lawrence R. Weschky, Sturgis
Daniel J. Wilhelm, MD, Port Huron
Mary Anne Ford, Staff

COMMITTEE ON MEDICAL LICENSURE AND DISCIPLINE

This Committee serves as a liaison to the Michigan Department of Licensing and Regulation and seeks and supports measures that will promote a fully effective Board of Medicine.

Rhoda M. Powsner, MD
Dearborn
Chairman

Gilbert B. Bluhm, MD, Southfield
Frederick B. Brown, MD, Muskegon
Ricardo Chalela, MD, Washington
Jerry Drake, MD, Dearborn
Ben R. Fajardo, MD, Mt. Clemens
James L. Fenton, MD, Bay City
Robert D. Gibson, MD, Newberry
William J. Kube, MD, Kalamazoo
Donald H. Kuiper, MD, Lansing
Devinder K. Mahajan, MD, Taylor
James A. O'Neill, MD, Clarkston
Bernhardt L. Pederson, MD, Bay City
Arthur Rose, MD, Southfield
Larry J. Sell, MD, Detroit
Orlando S. Sison, MD, Detroit
Robert A. Teitge, MD, Warren
Vernon C. Urich, MD, Flint
Theodore S. Vanderveen, MD, Grand Haven
Scott W. Woods, MD, Ypsilanti
John A. Ingold, MD, Consultant, Royal Oak
Daniel R. Farhat, Staff

COMMITTEE TO REVIEW MEMBER INSURANCE PROGRAMS

This Committee reviews existing and proposed insurance benefit programs for MSMS members and makes recommendations to the Board of Directors.

B. David Wilson, MD
Kalamazoo
Chairman

Susan E. Adelman, MD, Detroit
Jack L. Barry, MD, Bay City
K. B. Herrington, MD, Bad Axe
James E. McGillicuddy, MD, Lansing
Kenneth S. Merriman, MD, Hastings
Willys F. Mueller, MD, Fenton
Robert E. Paxton, MD, Fremont
Kenneth J. Ray, MD, Trenton
William B. Cheeseman, Consultant, East Lansing
Richard M. Campau, Staff

COMMITTEE ON MEMBERSHIP RECRUITMENT AND RETENTION

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to the Board of Directors and conducts personal recruiting efforts when needed.

Dorothy Kahkonen, MD
Detroit
Chairman

Waheed Akbar, MD, Saginaw
R. Jack Chase, MD, Grand Rapids
Jean A. Craig, MD, Grand Rapids
Bruce R. Deschere, MD, Pontiac
Mrs. Pat Dolan, Portage
Karl J. Edelmam, MD, Ann Arbor
Angel Farina, MD, Garden City
Robert G. Fawcett, MD, Petoskey
Lorenz Kielhorn, MD, Jackson
Edward D. Lanigan, MD, Lansing
Mrs. Joyce Mann, Grand Rapids
Lee Marmion, MD, Grand Rapids
Michael S. Mittell, MD, Lansing
Kevin T. O'Donnell, MD, Southfield
Darrel J. Rosen, MD, Grand Rapids
Earl J. Rudner, MD, Southfield
Charles R. Schmitter, MD, Ann Arbor
Dolores J. Shelfoon, MD, Bloomfield Hills
John W. Tauscher, MD, Flint
Samir R. Yahia, MD, Detroit
Margo Hoornstra, Consultant, Lansing

Peter A. Levine, Consultant, Flint
Josephine LoFrano, Consultant, Detroit
William G. McClimans, Consultant, Grand Rapids
Mary Sue Meyer, Consultant, Birmingham
Sallie Schiel, Consultant, Ann Arbor
Deborah Zannoth, Staff

LIAISON COMMITTEE WITH MICHIGAN DEPARTMENT OF PUBLIC HEALTH

This Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concern.

Douglas A. Mack, MD
Grand Rapids
Chairman

E. Joseph Alberding, MD, Portage
Elaine L. Atallah, MD, Farmington Hills
Bradley T. Barnes, MD, Rochester Hills
Mrs. Evelyn Dykewicz, Flint
William E. Hill, MD, Pontiac
Mary L. Jackson-Hammond, MD, Detroit
Ronald L. Krome, MD, Royal Oak
Donald W. Lawrenchuk, MD, Livonia
Kenneth D. McClatchey, MD, Ann Arbor
Virginia Y. Mesa, MD, Detroit
David C. Nolan, MD, White Cloud
John G. O'Rourke, MD, Jackson
John C. Peirce, MD, Grand Rapids
Frank L. Pettinga, MD, Muskegon
Mary Anne Ford, Staff

MICHIGAN DOCTORS POLITICAL ACTION COMMITTEE BOARD OF DIRECTORS

Peter A. Duhamel, MD, Rochester
Chairman

Mitchell A. Rinek, MD, Lansing,
Secretary/Treasurer
Larry J. Andreini, MD, Escanaba
Jack L. Barry, MD, Bay City
Jill Berglund, Kalamazoo
Joseph J. Berke, MD, Detroit
Donald G. Blain, MD, Mt. Clemens
Cathy O. Blight, MD, Flint
Donna Chase, Grand Rapids
William D. Doebler, MD, Holland
Lionel E. Dorfman, MD, Battle Creek

Continued on next page



Powsner



Rinek



Rovner



Springer



R. Stone



T. Stone

SPECIAL REPORT

MSMS COMMITTEES/Continued

Domenic R. Federico, MD, Grand Rapids
John A. Feemster, MD, Southfield
Richard H. Gascoigne, MD, Adrian
Richard P. Heuschele, MD, Saginaw
Cecil R. Jonas, MD, Southfield
Mark D. Kolins, MD, Grosse Pointe
Robert A. Mengebier, MD, Petoskey
Marsha Milburn, MD, Lansing
Fred E. Patterson, MD, Jackson
Robert E. Paxton, MD, Fremont
Thomas C. Payne, MD, East Lansing
Krishna K. Sawhney, MD, Farmington Hills
Marguerite R. Shearer, MD, Dexter
Gary S. Smith, MD, Midland
Thomas E. Stone, MD, Muskegon
Floyd S. Tukel, MD, Dearborn
B. David Wilson, MD, Kalamazoo
Bernard J. Woodley, MD, Trenton
Louis R. Zako, MD, Dearborn Heights
Daniel R. Farhat, Staff

LIAISON COMMITTEE WITH MICHIGAN PEER REVIEW ORGANIZATION (MPRO)

This Liaison Committee monitors the activities of the federal peer review organization in Michigan (MPRO), provides policy input to MPRO on medical and operational issues, meets with MPRO representatives to discuss matters of mutual interest, and assists individual physicians in dealing with problems or concerns they may have with MPRO.

Robert C. Packer, MD Muskegon Chairman

Joseph A. Arena, MD, Birmingham
Kenneth A. Brown, MD, Detroit
Gerhard C. Endler, MD, Grosse Pointe Woods
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Hagadorn, Inc. was formed in 1987 and is a joint venture between the Michigan State Medical Society and the Michigan Physician Mutual Liability Company. It expects to generate non-dues income for MSMS, and its first project is to build an 87,000 SF office building in East Lansing. The major tenant in the building will be MPMLC, when it is completed in December 1989.

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Physicians Service Group — Its name says a lot

By Michael R. Kelly

As chief of insurance marketing for Physicians Service Group Inc. (PSG), an MSMS subsidiary, a major part of my position involves traveling around the state and speaking before hundreds of physicians each year. It has become obvious to me that a very high percentage of our MSMS members are unaware of PSG — what it is and what it does. This is unfortunate as PSG is an organization whose sole purpose is to make the lives of physicians less complicated, both on a personal and a professional level.

Physicians Service Group is just what the name implies — offering such services for physicians, their families and employees as health and dental benefits which are serviced by PSG. Why is this important? Why should physicians take advantage of PSG services? Because PSG offers *quality, personal service*. With PSG there is no need for you to explain your situation to numerous service representatives you don't know, and who don't seem to care!

PSG offers a personal touch that is unavailable and impossible when working with large health organizations. PSG service representatives ultimately work for physicians who are members of MSMS. In a very real sense, PSG service reps are an extension of your office, they are part of your staff. Therefore, our representatives have more invested in solving your problems and answering your questions accurately the first time they are asked.



Other projects that are available through PSG are: practice management; IC Systems Inc.; Medical Billing Service Inc.; Merchant Credit Cards; a series of educational seminars; MSMS Member Gold Card, with credit lines up to \$15,000; discount magazine service; and much more that is being considered for the future.

By the end of 1988, PSG, in cooperation with other sections of MSMS, will have sponsored 12 seminars in various locations throughout Michigan. The seminars have covered a broad range of topics from risk management (approved for six hours of Category I Credit), to a retirement seminar geared toward physicians and their spouses.

During 1989, PSG hopes to increase the number of seminars to 24 and in turn, increase its practice management activity. This will be done through PSG referrals to our field of experts. By increasing the seminar and practice management activity, MSMS should see an expanded aware-

ness of PSG services.

Support of these and future programs offered by PSG will have a positive and productive outcome that will affect your association and consequently, you as a physician on a personal level.

It is now, and will always remain, our goal to deliver quality, personal service to our membership — as a subsidiary of your association we guarantee it!

The following letter from a physician helps to define in concrete terms what PSG and its products are all about: "Thank you so much for cutting through the red tape and expediting the production of my family insurance."

Another physician wrote: "You folks at MSMS have made me proud to have been a member all these years."

I hope this short article has at least given you, a member of MSMS, a good reason for supporting PSG by using our products and services. Remember, we work only for physicians. □

MSMS, MHA and State Bar launch organ donor campaign

By David K. Fox

“Break the Silence,” a statewide public service campaign by physicians, attorneys and hospitals to increase awareness of the acute need for organ and tissue donations, was kicked off October 19 at a joint press conference in Lansing.

MSMS President Fred W. Bryant, MD, along with MHA President Spencer C. Johnson and State Bar President Donald L. Reisig unveiled the campaign to media representatives at State Bar headquarters. Elements of the campaign include 30-second public service announcements for television and radio and a brochure discussing organ donation which will be distributed through hospitals and physician and attorney offices.

This joint effort originated last November in the Interprofessional Liaison Committee with the State Bar of Michigan.

Physicians interested in distributing “Break the Silence” brochures may order them by writing to “Break the Silence,” Department of Communications, Michigan State Medical Society, P.O. Box 950, East Lansing, 48826-0950. There is no charge to MSMS members for these brochures.

The effort focuses on the need for families and friends to discuss the donation process and encourages Michigan residents to “Break the Silence” surrounding organ and tissue donation.

Mr. Fox is chief of media relations for MSMS.

BREAK THE SILENCE



Michigan Hospital Association
Joint Effort of MHA, MSMS
Michigan State Medical Society

The theme of the “Break the Silence” campaign was developed after careful consultation with Michigan’s key donor agencies. They indicated that the biggest reason for shortages is not the unwillingness of individuals and families to donate, but the lack of awareness on the part of the public about donor procedures.

“We in the medical field realize that transplanting tissues and organs is no longer an experimental procedure. It’s an everyday reality,” MSMS President Fred W. Bryant, MD, said at the press conference.

“Less than a generation ago, the procedures being done today could not even have been considered,” Doctor Bryant said.

One of the major changes that has taken place in transplant surgery, Doctor Bryant pointed out, is the development of cyclosporine, the immune suppressant to combat rejection after trans-

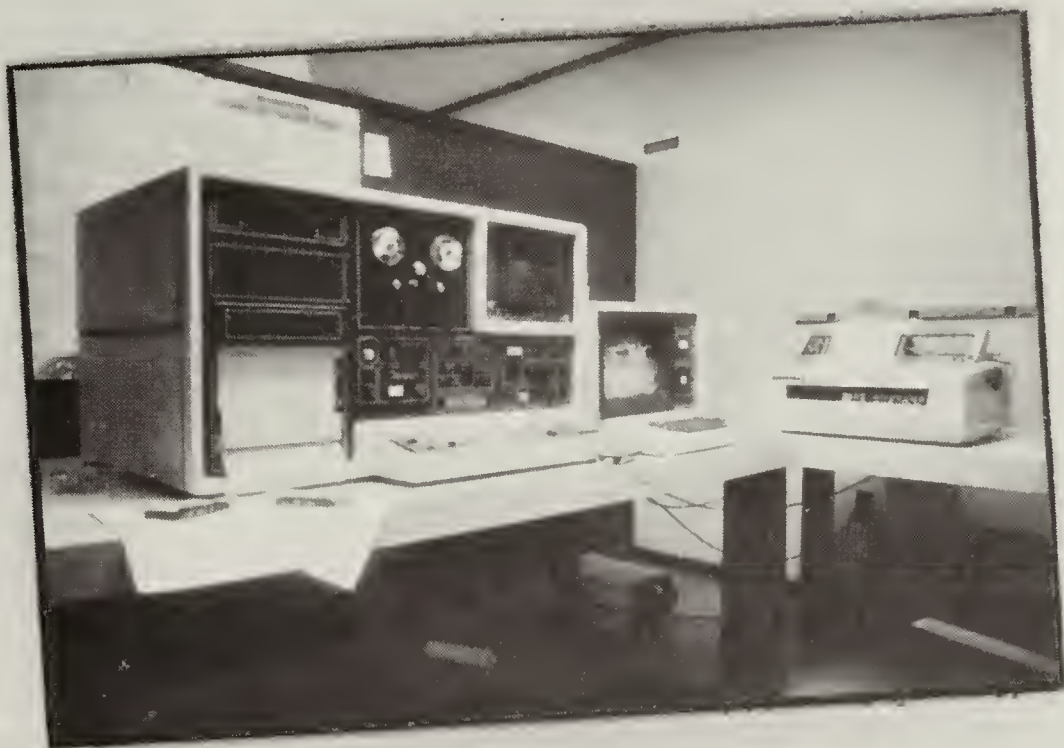
plant. Currently then, the major limiting factor is simply the shortage of donated organs.

In Michigan, 683 people are waiting for a kidney transplant, 32 are waiting for a heart or heart-lung, and two are waiting for liver donations. Over 1,000 people are waiting for bone or tissue donations.

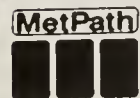
In Michigan, hospital staff members are required by law to ask next-of-kin for the organs and tissues of a family member who has died. But all agree this can be the most inopportune time to be making such a request. That is why the goal of the “Break the Silence” campaign is to get family members to talk about the issue and to make individual wishes known before an emergency situation arises.

Donor agencies working with the three professional groups are the Organ Procurement Agency of Michigan, the Michigan Tissue Bank, the National Kidney Foundation of Michigan, the Michigan Eye Bank and Transplantation Center and the Transplant Policy Center at the University of Michigan. □

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HEF is working to promote healthy living in Michigan

By Chad B. Munger

While Michigan physicians have many important responsibilities to medicine and their professional lives, they also must stay in touch with the subtle day-to-day lifestyles of the people they serve.

John R. Ylvisaker MD, president of the Health Education Foundation, a non-profit charitable organization created and sponsored by MSMS, is committed to proclaiming the very important, yet less apparent, role of MSMS as a leader in health education. That role, according to Doctor Ylvisaker, involves providing a vehicle by which groups and individuals can learn to make healthy decisions for themselves and their communities.

"One role of the Foundation is to provide the citizens of Michigan with a service which says we are not here only for the sick and the dying but to help people develop a good quality of life," says Doctor Ylvisaker. Under the direction of Doctor Ylvisaker, the Health Education Foundation has begun to do just that.

While the Foundation once believed its limited resources were best used by providing financial aid to medical students, it now believes that funding projects affecting state health issues is the best way to help promote health education.

The Foundation underwent several changes when it shifted its emphasis from financial aid to project funding, both in terms of its orientation toward health edu-



cation and its role in the MSMS structure. The most visible of these changes: adoption of independent project funding.

Projects funded by the Foundation are intended to be beneficial to the citizens of Michigan, not necessarily to physicians, according to Doctor Ylvisaker. To assure this, most funded projects are not technically or scientifically oriented toward medicine. Instead, they tend to focus on the clinical, sociological and economic concerns of health.

All projects are Michigan based, non-governmental, non-religious, non-political and non-discriminatory in nature. Most importantly, projects funded by the Foundation are oriented toward education or service in areas that promote healthy lifestyles and directly affect the peo-

ple of Michigan.

The list of projects funded by the Foundation is impressive and continues to grow. Grant recipients include: Oakland University, for a disease prevention program; The Michigan Health Council, to help defray general operating expenses; The Genesee Intermediate School District, for an adolescent substance abuse prevention program; Michigan State University, Department of Family Practice, for Lipid Lowering Study in Primary Care Patients; and most recently, the MSMS Auxiliary, for a drug prevention program that will be used in public schools throughout the state.

One of the projects that is most representative of the Foundation's goals, according to Doctor Ylvisaker, is a grant to the Mea-

dowbrook Health Enhancement Project. This project, which received a \$25,000 grant (the largest ever given by the Foundation), is committed to doing a long-term study of the benefits of encouraging people to live more healthy lifestyles. The study establishes a program of exercise, nutrition and lifestyle changes for a group of working men and women. The effects of these lifestyle changes are evaluated in terms of the physical health of the participants, their impact on the use of the local medical system and on the medical costs to employers.

"The thing that makes this project so representative of what the Foundation is all about is that it is instructional and beneficial to individuals as well as to employers and industry," says Doctor Ylvisaker. "The results of this project may well have impact on things like insurance rates and structure, thereby producing a benefit for society in general."

The role of the Foundation in these projects is to help them become established and gradually self-sufficient. The Foundation will not fund projects on an ongoing basis. Its limited funds are intended to be short-term start-up funds for new projects and are to be used by as many different groups as possible.

The role of the Foundation is limited only by its financial resources, according to Doctor Ylvisaker. "The ultimate objective of the Foundation is to become a multi-million dollar force

in health education funding," he says. "We would like to emulate the successful programs already established in Minnesota and Pennsylvania. Eventually we would like to become the primary philanthropic arm of MSMS."

Part of the Foundation's new commitment to active participation in health education and re-

search projects includes soliciting funds on an annual basis from MSMS members.

"We need to rely on broad-based support from our members," says Doctor Ylvisaker. "What strikes me is that people at the time of the Foundations'

Continued on next page

The following are contributors to the Foundation:

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Billy Ben Baumann, MD
Cathy O. Blight, MD
M. Joseph Bowler, MD
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HEF/Continued

creation were willing to give so much. We need to be as forward-thinking and committed to health care as our counterparts were 50 years ago."

The internal support Doctor Ylvisaker is seeking has begun to pick up. In 1988, 51 members contributed a total of almost \$6,000 to the Foundation. Leland E. Holly, II, MD, became the Foundation's first benefactor in 1988 with his generous gift of

\$1,000. He was recognized for his contribution at the September 1988 MSMS Board meeting.

There are two major obstacles to reaching the Foundation's financial and philanthropic goals, according to Doctor Ylvisaker. The first is visibility; the second is support from MSMS members.

As a reflection of the Foundation's new image, and its desire for increased visibility, the Foundation now touts a new logo, issues an annual report, has hired a part time staff person, and is actively seeking the involvement

of people outside of MSMS.

"Getting the involvement of people outside of MSMS is worthwhile because it provides direct contact with the outside community and brings in the expertise of people with backgrounds in the operations of a Foundation," says Doctor Ylvisaker.

MSMS has also become more involved with the operations of the Foundation, providing office space and staff support.

"What the Foundation needs," says Doctor Ylvisaker, "is all the enthusiasm we can put into it."

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IN MY OPINION/Continued

prisoners by a "contract physician" in any setting — "on site" at a prison, in a local hospital, or in the physician's office.

Unfortunately, the Michigan House of Representatives is not likely to consider this bill in this session. It was referred to the Judiciary Committee and appears to have died there.

I have discussed this situation with colleagues in the state. There is a firm conviction that the incarcerated, whether by city, county or state government, represent a high risk litigation population and that physicians are reluctant to treat conditions that are not emergencies.

MSMS intends to press for legislation to address this problem. There is a societal obligation to

provide the same level of health care to prisoners as to the populace in general. Physicians asked to provide that care should, however, not be placed at increased personal liability.

Your committee on legislative policy welcomes your comments. Please address them to Mr. Terry Vanderveen, MSMS headquarters, P.O. Box 950, East Lansing, MI 48826-0950. □

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea) 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever) 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
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Consider a Simplified Employee Pension Plan for your practice

By Larry K. Winegar

Editor's note: This is the third in a series of articles on practice management. These articles are being presented as a service of Physician Service Group Inc., an MSMS subsidiary. For more information on this or future articles, contact Amy Fistler at MSMS, (517) 337-1351.

Today, more and more small businesses are choosing to set up retirement plans. And they're discovering that a Simplified Employee Pension (SEP) plan is an excellent way to provide the benefits they desire. Many medical practices, especially new ones, may want to consider adopting a SEP as well.

Adoption of a qualified retirement plan may have been previously delayed because of the administrative costs and complexities. SEPs are easy to establish. Unlike many other retirement plans the employer is not required to file a complicated 5500 report with the IRS. Preparation and filing of a Summary Plan Description with the US Department of Labor is not required either.

Coverage requirements for SEPs are more stringent, however. But even here there is the benefit of some flexibility:

- Employees must be covered if 21 or over *and* have earned at least \$300 in *three* of the last five years.

Mr. Winegar is an account executive, Roney & Co., East Lansing.

- The employer may elect *less* restrictive requirements.
- Eligibility requirements may be changed *every* year, provided they are not more restrictive.
- Employees covered by a collective bargaining agreement may be excluded.

Contribution levels are flexible. Contributions are *never* required to be made. The employer can choose to contribute up to the maximum (15 percent of the first \$200,000 of each participant's compensation) one year and then no contribution the next. Contributions must be made on a pro-rata basis, however, for each eligible participant's account.

SEP contributions are, of course, a deductible business expense. They also do not affect your employees' current tax liability. Investment earnings are tax deferred until the retirement of each participant. Employers *may* even allow the employee to choose how their individual benefit will be invested. This may enhance their appreciation of this benefit by providing them with a certain level of control over their retirement security. SEP's are inexpensive to administer. There is usually no, or a limited, charge to establish a SEP, and the services of a plan administrator are generally not required. The only continuing expense is a trustee fee, which is \$30.00 per participant, annually.

A SEP can be established *after* your practices' fiscal year-end. A SEP can be set-up and funded up

to the due date of your business tax return. In fact, SEPs are the only retirement plan that has this feature.

Another feature that a SEP may contain is a salary deferral plan. This feature is similar to a 401(K) plan, usually found only in large corporations. The salary deferral plan allows each participant to defer up to 15 percent or \$7,313.07 of their compensation. Salary deferral SEPs can be adopted with the following requirements:

- Employer must have less than 25 employees.
- At least 50 percent of eligible employees participate.
- No highly-compensated employee may defer more than one-and-one-fourth times the average for the federal percentage of the non-highly compensated.
- Each participant may contribute up to 15 percent of their pay, but not more than \$7,313.07.

A SEP can be a simple solution to retirement planning, yet offer sophisticated retirement options, at a limited cost, with limited administrative burden. □

LETTERS/Continued

medical profession in the US, the twin measures of Congressmen Solarz and Bates can aptly be considered as the light at the end of the tunnel.

With this encouraging development, the GFMSs and their sympathizers must now move concertedly to give a big push to part of the laws of the land. The ball is now in the GFMSs' court, so to speak. They cannot afford to fumble now, much less be complacent in the face of their

problems; otherwise, the light at the end of the tunnel will just as soon become merely a mirage.

Resistance to these measures there will be, especially coming from the direction of those who feel threatened by professional competition. Nor can objections from some congressmen and states, dictated by the pressures of conflicting professional and constituency interests, be underestimated. These are quite formidable and should, therefore, not be taken lightly.

All these considered, it is evi-

dently imperative that GFMSs and all those who believe in their cause, should put their shoulders to the task of gathering grassroots support before it is too late. More than at any time before, they should take a united stand and with resolution and dynamism, launch a vigorous congressional lobby.

In the ultimate reckoning, the passage of HR 3273 and 3241, and the overall success of the GFMSs' fight against discrimina-

Continued on next page

AIM HIGH

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LETTERS/Continued

tion, are, to be sure, in their own hands. Afterall, they and only they can more than anybody else, man their rampart and do their battle.

P.S. A more recent measure, Senate Bill 1868, was introduced in the US Senate by Senator Patrick Moynihan of New York.

Jose L. Evangelista, MD
President
Association of Philippine
Physicians of America

Rural health report on target

I agree with the tenor of the special report on rural physicians, edited by Judy Marr in the August 1988 issue of *Michigan Medicine*.

The Michigan State Medical Society (MSMS) should follow the lead of the Wisconsin Medical Society and make greater effort on behalf of rural medicine. Creation of a task force would be a first step. Perhaps a selective

medical school admission policy could be another way to increase the number of primary care physicians in under-served areas. (Rabinowitz, H.K. Evaluation of a Selective Medical School Admissions Policy to Increase the Number of Family Physicians in Rural and Underserved Areas. *NEJM*. 1988; 319:480-885.)

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

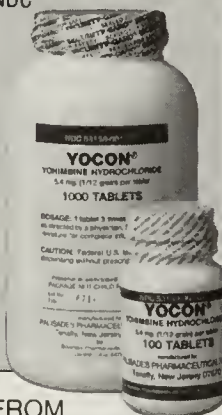
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: William L. Bendel, MD

Action, Date Taken: Voluntary surrender of license, October 21, 1988

Reason: Substance abuse

Name: Zack Bernard Brown, MD

Action, Date Taken: Revocation, November 10, 1988

Reason: Criminal conviction/drug related

Name: Howard Burley, MD

Action, Date Taken: Suspension one year, November 21, 1988

Reason: Mental or physical impairment

Name: Leon E. Butler, Jr., MD

Action, Date Taken: Summary suspension, August 17, 1988

Reason: Criminal conviction/drug related

Name: Dale Dudley, MD

Action, Date Taken: Summary suspension, August 17, 1988

Reason: Criminal conviction/drug related

Name: Frank W. Jeffries, MD

Action, Date Taken: Reprimand, October 21, 1988

Reason: Negligence

Name: Kirk R. Klemme, MD

Action, Date Taken: Probation—two years limited license, August 19, 1988

Reason: Mental or physical impairment

Name: Leslie David McBeath, MD

Action, Date Taken: Denied, June 27, 1988

Reason: Reinstatement

Name: Richard L. Orders, MD

Action, Date Taken: Voluntary surrender of license, July 20, 1988

Reason: Criminal conviction/insurance fraud



Revision of the Vital Records Forms for Michigan

Redesigned Forms to Be Used in 1989

By George Van Amburg, State Registrar
Office of the State Registrar

Michigan physicians will be asked to use new vital records forms beginning January 1, 1989. The new forms, which include certificate of birth, certificate of death and fetal death report, will be in place for roughly 10 years, from 1989 through the end of the 1990s.

The revision of these forms was necessitated by a revision to the national standard vital records forms. The recent revision to the model certificate – to be followed by all 50 states – was released in early 1987 and was intended for implementation in 1988. However, Michigan elected to delay implementation of the new model to allow for adequate input from within Michigan on the redesigning of the forms.

This month's **Physician's File** explains the revision process and describes how each vital records form has been changed.

The Revision Process

Any change to the national standard forms for vital records creates a rather sweeping effect across the country. Each state must adapt to the change as best it can. As each state revises the process within its territory, changes in practices within hospitals, physicians' offices, funeral homes and local registrars' offices become necessary. As new data becomes available, the impact on the research community completes the course of change created by the revision to these important documents.

This broad effect causes the process of forms review and revision to become lengthy and painstaking in order to assure full participation in the decision process by those affected by any change. This is important at the national level as the model forms are evaluated and modified.

The model certificates were revised through a series of steps which began in 1983 and ended with the release of the revisions in 1987. This process began with a large survey on each of the vital records forms. The survey was aimed at those directly involved with the documents and the

resulting statistics and probed what was right, what was wrong and what might change on each form. Working groups were established to take up the task of developing the model forms for use into the 1990s. The representation within these groups included the American Medical Association, the American Hospital Association, the American Association of Obstetricians and Gynecologists, the National Association of Medical Examiners, and the American Medical Records Association. Others represented included state vital records offices, local registrars, funeral directors and researchers from several universities. These working groups developed and recommended forms revisions which were then translated into the new national standard forms.

Upon adoption of the new model forms, alternative forms for Michigan were developed as proposals. Working groups were established within Michigan to design forms for the state that adopt the key changes introduced by the new model forms. The Michigan State Medical Society was an active participant in the deliberations of the group.



Description of the Changes

The nature of the revisions that have been made to these forms is either clarifying an item already present, changing the manner of collecting the information, dropping information no longer of use or adding new items to the form. The new features for each of the three forms completed in part by physicians is provided to highlight how reporting will change in 1989.

Death Certificate

The certificate of death will no longer be a carbon form. The length of the form will increase to 14 inches. The bottom three inches of this form is a perforated instructional tear off stub, on which updated instructions are provided. The information sections are reorganized to place the funeral director's sections on demographics and disposition at the top of the form followed by the medical portion. New items that have been added to the funeral directors section include the decedent's zip code, ancestry, education and the funeral director's license number. Those changes that are of consequence to the certifier are listed below.

Margin Entry of Decedent's Name

A specific margin entry line has been added to the form for use by hospitals and physicians who start the certificate completion process. This allows the physician or hospital staff starting the record to avoid completing the decedent's name item by entering the name in the margin instead. This would eliminate name errors and assure the funeral director has the opportunity to enter the full name as supplied by the informant without having to discard the certificate first signed by the doctor. Providing a space for this margin entry should help to encourage this practice which was introduced several years ago. Note that a margin entry of the name is not a requirement. Rather an entry can be made when appropriate.

Expanded Cause of Death Section

The cause of death section has been expanded to permit additional entries at the discretion of the certifier. Clarifying instructions have been inserted within the section to advise that all lines need not be completed and, most importantly, that cause of death entries should reflect those conditions which brought on the death rather than the mechanism or the mode of death. This latter instruction is an important effort to assure that the certifier explains the pathologic and physiologic sequence of events that led to death rather than, as often happens, explaining the means by which the cause of death exhibits its deadly effect.

Autopsy Findings

The autopsy findings item serves to indicate if the causes of death listed are based upon autopsy findings. The item is to be completed by the physician certifying to the cause of death. This item reinstates a similar question that was on the Michigan form prior to 1978. The item may be completed with a yes or no response. If there was no autopsy, the item may be left blank.

Medical Examiner's Case Number

Added at the request of the Michigan Association of Medical Examiners, this item permits the entry of a medical examiner's case number by the medical examiner as the certificate is certified. The number is to be entered at the discretion of the local medical examiner and may be left blank.

License Number of Physician

The item serves to assure the proper identity of the certifier. This information will aid in instances where contact with the physician is later indicated.

Two items have been deleted from the certificate. The citizenship of the decedent was deleted as its function of identifying deaths to foreign citizens no longer exists.

Physician's FILE

The hour pronounced dead which is currently within the medical examiner's section has been dropped since it is felt to have no legal significance.

The style and general organization of the medical portion of the death record remain quite similar to the format used since 1978. Retaining this style does cause Michigan to depart from the format used in the model certificate. The national standard form requires a certifying section to be completed by the physician who pronounces death and then a separate section for the physician who certifies to the cause of death. The latter physician may or may not be the same as the pronouncing physician. The format for certification promoted by the national standard was felt to be cumbersome and was rejected. Beyond this deviation in format, however, the changes introduced on the Michigan form are predicated upon changes in the model certificate, excepting only the medical examiner's case number item.

Birth Certificate

The 1989 version of the Michigan live birth certificate will differ from the current form in size, in the format used to record selected items and in regard to the items being collected by the form. The new certificate will be 14 inches in length compared to the current 11 inches. The form will continue to be a carbon form but will be reversed with a short original legal record and a 14 inch confidential statistical carbon copy.

Specific additions to the form include an item to enter the mother's full name instead of her name before marriage, the ancestry of the parents, the expected payment source and medical record number and transferral information on the mother and the infant. Items on the method of delivery, obstetric procedures used, abnormal conditions of the newborn and the mother's weight gain, and use of tobacco and alcohol are also included.

Perhaps the most significant change in the form is the shift from the use of open ended items for reporting medical conditions to the use of check box listings. This change results directly from the change in the model certificate. The check box format is predicated upon two key factors. First is a general acceptance of the fact that the present reporting of medical conditions using open ended items is very poor. The second point is that the use of check box certificates in selected states, most notably New York and Maine, has caused a strong improvement in the quality of reporting. This improvement is believed to be due in part to the clear listing of conditions and in part because of an increase in the direct involvement of the physician in supplying the data.

To aid hospitals in the proper management of the information that will be needed to accurately complete these new live birth certificates, the hospital worksheet will be redesigned in consultation with representatives from the Michigan State Medical Society, the Michigan Medical Records Association, the Michigan Hospital Association and the Michigan Osteopathic Hospital Association. This new worksheet will be designed to be employed as is the case now or as an attachment to the chart so as to collect the key items of information directly from the physician and right at the time of delivery. A second worksheet for distribution to the mother prior to delivery is also planned. Complementing this effort, computer software for use by hospital staff is also under development which will permit the use of personal computers to capture, edit, store and to print birth certificate information.

Three items have been deleted from the revised form. These items are the informant's relationship to the child, the indication that the newborn's eyes have been treated with a prophylaxis and the item on whether the mother had been tested for the presence of syphilis. These latter two procedures will



remain as required medical procedures but will no longer be reported on the birth record.

Fetal Death Report

The changes to the fetal death report in 1989 are quite similar to the changes made to the live birth certificate. The form will continue to be a confidential and anonymous

report. The items added to the birth certificate are included on this new form as appropriate. This new form contains the occupation and industry items as found on a certificate of death. The form length was increased to 14 inches to accommodate the check box listings for medical items.

Summary

Instructional material on the proper completion of each of these forms has been prepared. It is available from the state registrar's office and most hospitals as are drafts of the new forms. Distribution of the forms will occur in the fall and will be directed toward funeral homes, local registrars and hospitals. Individual requests for forms supplies from physicians can be directed to the local registrar for your area or to the state registrar. Requests made of the state office should be directed to:

George Van Amburg, State Registrar
Office of the State Registrar
P.O. Box 30195
Lansing, Michigan 48909
(517) 355-8656

The forms are to be used in the reporting of all live births, reportable fetal deaths or deaths occurring on or after January 1, 1989. A supply of the current forms should be retained into 1989 for reporting events which occurred in 1988 until all such reports have been accepted for filing.

The revision of these important forms is part of a periodic program of review and update that is essential to keeping the documents current with the needs of the times. Any change to an established process can, nonetheless, cause consternation and require adjustments. A smooth transition to these new forms is a goal that can be met only with the support and cooperation of those many people involved, and especially with the conscientious effort of the physicians that are called upon to complete these documents.



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Gans



Conteas

Bruce M. Gans, MD, has been appointed president and chief executive officer of the Rehabilitation Institute, Detroit Medical Center (DMC), and physiatrist-in-chief of the DMC. He replaces Leonard F. Bender, MD, Detroit, who is retiring.

Chris Conteas, MD, Detroit, is the new vice chief for the Grace Hospital Department of Medicine, Gastroenterology Division. Doctor Conteas was formerly a staff gastroenterologist at Harper Hospital.



Mariona

Federico Mariona, MD, a Dearborn perinatologist, has been appointed director of the Maternal-Fetal Medicine section of the Center of Excellence for Women and Children, Oakwood Hospital. Mariona is a specialist in high-risk pregnancies.

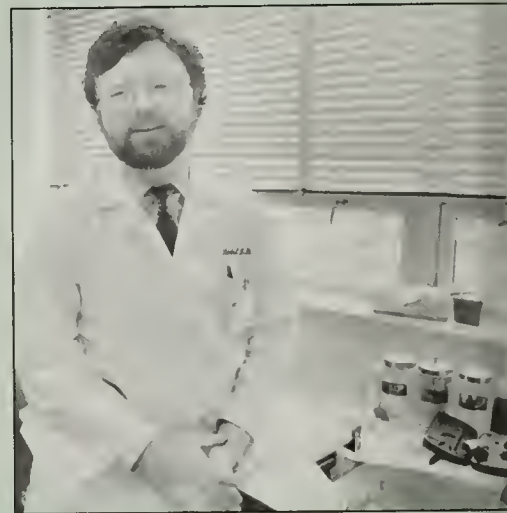
Detroit-area physician coordinates Polish worker medical effort

Amidst the striking and military suppression of striking, one Detroit-area physician is working in Poland with a committee established by Nobel Prize-winning "Solidarity" leader Lech Walesa to improve the health of the Polish people.

Michael R. Harbut, MD, MPH, a Southfield specialist in occupational medicine, was appointed by the International Rescue Committee to coordinate medical efforts as mandated by the United States Congress in its appropriation to that agency. Congress had initially earmarked financial aid for the embattled Polish Union "Solidarity," but its leadership felt that such assistance would be negatively perceived by the Polish government. Consequently, Walesa appointed a committee of internationally-respected physicians and scientists, to which Doctor Harbut is advisor, which has been charged with developing mechanisms to improve the quality and quantity of medical services in that country.

"I am helping them establish a system of diagnostic clinics in the disciplines of Occupational Medicine, Cardiovascular Medicine, Gastroenterology, and Hematology," said Doctor Harbut.

"The lack of rudimentary technology in even the largest



Doctor Harbut

hospitals is striking," he added. "We hope to provide the necessary machinery to change that situation, and also assemble a team of US volunteer physicians to travel to Poland with me later this year to teach our Polish colleagues its use."

Doctor Harbut, who is also medical advisor to the Michigan AFL-CIO, stated that he has initiated discussions with the Internal Medicine programs at Providence Hospital and Wayne State University to establish exchange programs with equivalent Polish institutions.

"In my most recent meetings (July 1988) with both Mr. Walesa and the Polish Minister of Health, I perceived a mutual and clear desire to attempt to attack the growing problem of Polish illness as one of the most serious challenges of that society," Doctor Harbut said. □

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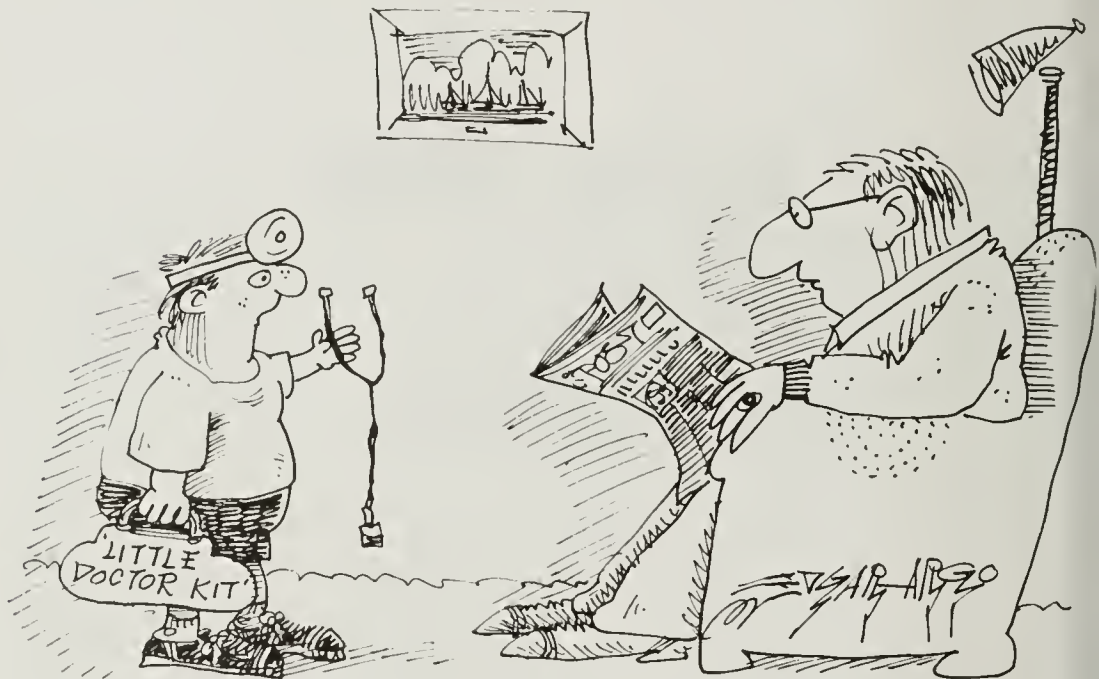
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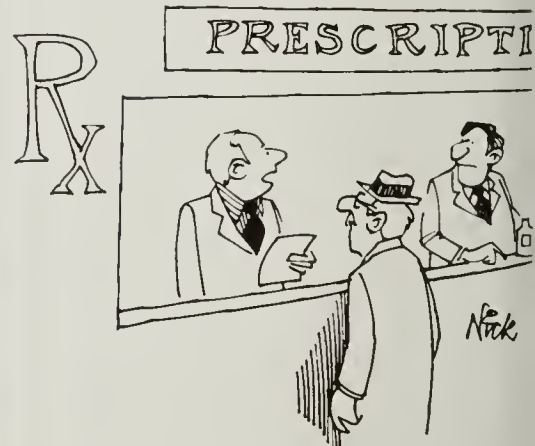
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Physician supply to outpace patient demand, AMA projects

Growth in physician supply is estimated to outpace patient demand for services by almost 10 percent by the year 2000, with the mismatch varying by specialty, according to a new book published by the American Medical Association's Center for Health Policy Research.

The book, entitled *Physician Supply and Utilization: Trends and Projections*, says the active physician population in the year 2000 will increase from the 1985 level by 23.8 percent. This will vary by specialty. (See chart.) The number of physicians in the medical subspecialties, pediatrics, anesthesiology, and emergency medicine is growing much faster than the physician population as a whole, the book says.

Between 1985 and 2000, utili-

zation of physician services is projected to increase by 14.5 percent. The fastest utilization growth is projected for general internal medicine and the medical subspecialties. This is caused by the aging of the US population as projected by the US Census Bureau,

according to the book.

The projected differential between supply and utilization is 9.4 percent by the year 2000. Although the physician supply is growing much faster than the utilization of physician services in the medical subspecialties, pediatrics, obstetrics/gynecology and emergency medicine, projected utilization in general surgery will grow faster than supply.

The book points out that these imbalances may result in physicians and patients changing their current behavior patterns. Physicians could respond by choice of specialty and the timing of their retirement. According to the book, such changes could ease the imbalance between the physicians supply and utilization trends.

Comparison of Changes in Projected Physician Utilization and Supply, 1985-2000

	Supply*	Percent Change Utilization**	Difference
All physicians	23.8%	14.5%	- 9.4%
Specialty			
General/Family	9.9	13.0	3.1
All Internal Medicine	36.6	24.0	-12.6
General Internal Medicine	27.0	24.6	- 2.4
Medical Subspecialists	51.8	23.4	-28.4
All Surgery	13.1	17.0	3.9
General Surgery	0.5	16.5	16.0
Surgical Subspecialists	19.9	17.1	- 2.8
Pediatrics	38.8	7.0	-31.8
Obstetrics/Gynecology	24.3	2.8	-21.5
Radiology	18.2	—	—
Psychiatry	14.0	19.4	5.4
Anesthesiology	41.7	—	—
Pathology	9.6	—	—
Emergency Medicine	69.4	6.2	-63.2
Other Specialties	18.1	14.8	- 3.3

*Total projected active physicians.

**Total physician contacts excluding telephone contacts (based on NMCUES and NHIS data).

SOURCE: AMA Center for Health Policy Research, 1988.

U-M receives \$3 million grant from NCI

The University of Michigan Medical Center has received a three-year, \$3 million grant from the National Cancer Institute (NCI) to conduct laboratory and clinical studies on the treatment of tumors in the liver.

The grant gives liver cancer patients several new research options in the treatment of their life-threatening condition— options

that may benefit patients who have failed to respond to, or are unable to use, conventional therapies.

Among the choices is a treatment using a combination of standard radiotherapy and drug infusion, and another using injectable radioactive glass beads to destroy cancer cells. The U-M Medical Center is the only institution in the country that has received federal Food and Drug Administration approval to conduct testing of the second therapy.

U-M investigators are hoping the new methods will produce fewer side effects than current treatments.

There are more than 60,000 persons with liver cancer in the United States. In 1987 there were 14,000 new cases of liver cancer, and 10,900 people died from the disease, according to the American Cancer Society. Liver cancer typically affects middle-age or older men and women.

Continued on page 728

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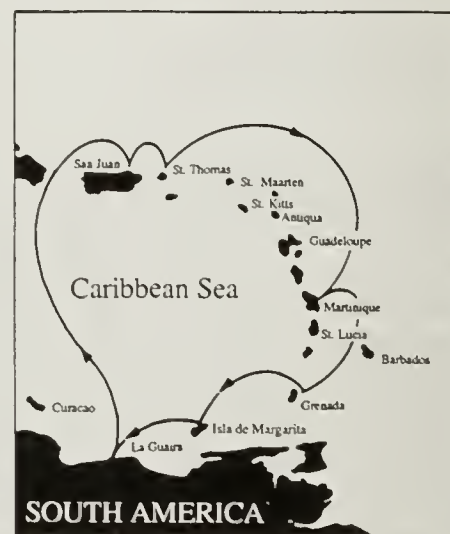
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NEWSFRONTS/Continued

Harper Hospital approved for unrelated bone marrow transplants

Harper Hospital, the first hospital in Michigan to offer bone marrow transplantation, has just been approved to become an official center for unrelated bone marrow transplants.

The designation, made by the National Bone Marrow Donor

Registry in St. Paul, Minnesota, makes Harper the only hospital in the state and one of 13 centers nationwide to offer the service.

The process of bone marrow transplantation offers hope for thousands of people every year who are stricken with certain blood related disorders. Traditionally, individuals who needed the transplant relied on their siblings or possibly one of the parents to donate marrow. With the inception of the national registry, which contains 18,000 names of possible donors, it is

now possible to locate an unrelated donor who has the necessary matching characteristics. The registry offers a last chance for patients who do not have a perfect match with a family member.

Lyle Sensenbrenner, MD, director of the bone marrow transplant program at Harper Hospital, says the program is important for Michigan residents. "By enabling us to tap into the unrelated donor pool, we can now offer this procedure to Michigan residents. This has been shown to be an effective treatment for a large number of life threatening diseases," he said.



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Statewide TB conference slated for December

"Tuberculosis Elimination—Michigan Responds to the National Plan" is the theme of a statewide tuberculosis conference scheduled for December 1-2 at the Sheraton-Oaks Hotel, Novi. The conference is being sponsored by the American Lung Associations of Michigan and Southeast Michigan, the Michigan Thoracic Society, and the Michigan Department of Public Health.

The conference will present the national strategy for the elimination of TB, provide an update on the diagnosis and management of TB disease and prevention, and describe the present

Continued on page 730

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NEWSFRONTS/Continued

status of TB in Michigan. The conference will also focus on certain significant aspects of the TB control, such as TB among the noncompliant, the homeless, and the institutionalized. The AIDS/HIV impact on TB will also be discussed.

The conference faculty consists of both locally and nationally renowned experts in TB control.

To obtain a registration form, contact Karen Krzanowski at the American Lung Association,

(800) 678-LUNG. Cost of the conference, which includes lunch on December 1, is \$75.00.

The conference meets the criteria for 10 credit hours toward the requirements for Michigan relicensure.

Participants needed for eating disorder treatment program

The Pediatrics Department of Children's Hospital of Michigan and Wayne State University

School of Medicine have recently received funds from the National Institute of Mental Health to treat 40 adolescent patients with an eating disorder defined by either Anorexia Nervosa or Bulimia.

Participants are being recruited for this program, which requires a family commitment. Program participants will be assigned to either family or individual therapy, will complete a series of questionnaires and will

Continued on page 732

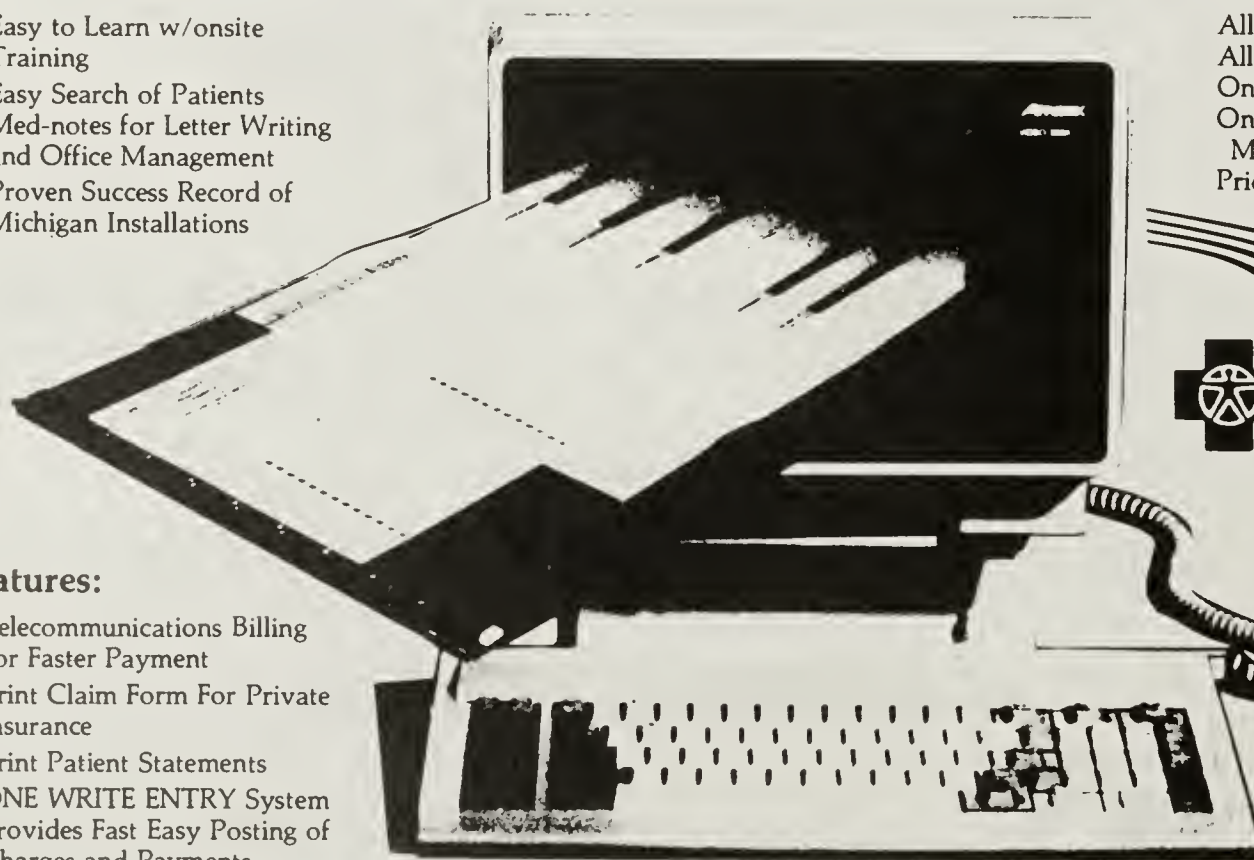
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NEWSFRONTS/Continued

attend weekly treatment sessions. Treatment with an additional year of follow-up care will be provided for approximately one year. Adolescent and young adult women aged 11 to 20 who live with both parents and meet the diagnostic requirements for anorexia nervosa or bulimia are eligible.

While the cost of this treatment is valued at over \$6,000, funding from the National Institute of Mental Health makes

treatment available to each patient and family at a reduced rate of less than \$1,000. The fees that are charged cover the costs of outpatient medical management. All psychological treatment and dietary consultation is provided at no cost to the family. Should the patient require hospitalization due to severe medical distress or starvation, the patient, family and/or third party reimbursers will be responsible for these costs.

This is a clinical research study in which two viable alternative outpatient treatments are being

compared: family therapy and individual therapy. The therapy sessions in either treatment are structured to assist the patient and her family in getting control of the symptoms of the eating disorder as well as to improve interpersonal functioning. The patient will also receive regular medical and dietary consultation.

Interested families should be referred to Doctors Arthur Robin or Thomas Koepke, at (313) 745-4878 to obtain further information and to schedule a screening appointment. □

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ANNUAL PERCENTAGE RATE:	9.00%	ANNUAL PERCENTAGE RATE:	10.00%	ANNUAL PERCENTAGE RATE:	11.00%
(The cost of your credit as a yearly rate.)		(The cost of your credit as a yearly rate.)		(The cost of your credit as a yearly rate.)	
Amount Financed:	\$1,000.00	Amount Financed:	\$2,000.00	Amount Financed:	\$4,000.00
(Amount borrowed)		(Amount borrowed)		(Amount borrowed)	
Credit Life & Disability Ins.:	\$ 15.85	Credit Life & Disability Ins.:	\$ 44.26	Credit Life & Disability Ins.:	\$ 128.68
TOTAL FINANCE CHARGE:	\$ 49.63	TOTAL FINANCE CHARGE:	\$ 214.56	TOTAL FINANCE CHARGE:	\$ 719.46
(The dollar amount the credit will cost you.)		(The dollar amount the credit will cost you.)		(The dollar amount the credit will cost you.)	
Total of Payments:	\$1,065.48	Total of Payments:	\$2,258.82	Total of Payments:	\$4,848.14
(The amount you will have paid after you have made all payments as scheduled.)		(The amount you will have paid after you have made all payments as scheduled.)		(The amount you will have paid after you have made all payments as scheduled.)	
12 Monthly Payments:	\$ 89.00	24 Monthly Payments:	\$ 95.00	36 Monthly Payments:	\$ 131.00
	Due 10th of each month		Due 10th of each month		Due 10th of each month

If your payment is one month or more late, you may be charged 20% of the interest due. You are giving a security interest in your credit union accounts in accordance with the "Pledge of Savings" on the reverse side. For additional information refer to the Note.

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APPLICATION/NOTE

1.

Name		
Address		
City	State	Zip
Employer	Monthly Income (Gross)	
Employer Address		Date Started
Home Phone #	Work Phone #	
Social Security #	Driver's License #	
Reference (other than spouse)	Spouse's Income	
Home: ☐ Own ☐ Rent	Mortgagee / Landlord Name	Monthly Payment
Debts Owed To	Balance Owed	Monthly Payment

The credit union reserves the right to request additional information, if necessary.

Amount you wish to borrow:

☐ \$1,000.00 ☐ \$2,000.00 ☐ \$4,000.00

2. Purpose of loan _____

Deposit funds to my:

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By signing here, you are applying for a loan marked above, and you agree to repay the loan with interest (FINANCE CHARGE) according to the terms stated herein if your application is approved by the credit union.

3. X _____
Applicant's Signature Date Account No.

X _____
Co-Applicant's Signature Date Account No.

Credit Life and Disability Insurance are not required to obtain this loan and will not be provided unless you check the "YES" box, sign below and agree to pay the extra cost listed in the examples shown on the reverse side.

1. I want Credit Life Insurance ☐ Yes ☐ No
2. I want Credit Disability Insurance ☐ Yes ☐ No

X _____
Member's Signature Date

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For security purposes, you must include a copy of your valid driver's license with this application.

You promise to pay the credit union the principal amount plus interest on the unpaid balance according to the payment schedule and rate listed in the "Truth-In-Lending Disclosure." The rest of the terms and conditions of this Note are listed herein. You also pledge your accounts in the credit union in accordance with the "Pledge of Savings." However, if payments on this loan are up-to-date, Borrower(s) can withdraw shares and/or deposits in excess of the outstanding loan amount.

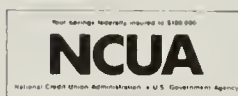
- A. Prepayment: You can repay all or any part of this loan at any time without penalty.
- B. Late Charges: Fines or charges may be imposed for late payments on this loan up to the maximum shown in the "Truth-In-Lending Disclosure" on the reverse side.
- C. Default: You are in default if you fail to make a payment on this loan on time. You are also in default under this Note if you are in default under the "Security Agreement" (if applicable) or under any other security agreement or real estate mortgage securing this loan.
- D. Acceleration: If you are in default, any part of this loan then unpaid and any other amounts you owe under the "Security Agreement" (if applicable) or under any other security agreement or real estate mortgage securing this loan are due and payable in full without notice to you (unless such a mortgage provides otherwise), at credit union's option.
- E. Waiver of Security: The credit union waives any security for this loan or for any refinancing of all or part of this loan or for any sum owing under any security agreement or real estate mortgage securing this loan, other than the security granted by the "Pledge of Savings" in paragraph G, by any security agreement or real estate mortgage securing this loan and security provided by statute.
- F. Completing Note: You authorize the credit union to complete this Note in any necessary respect if it is executed while incomplete.
- G. Pledge of Savings: As security for all amounts owing under this Note and under any security agreement and/or real estate mortgage securing this loan, you pledge all shares and/or deposits (including earnings and additions) you now or in the future have in this credit union, but only up to the total of such amounts unpaid from time to time. If you default, you authorize the credit union to apply such shares and/or deposits to payment of these amounts. This pledge does not apply to shares and/or deposits in an Individual Retirement Account (IRA); Keogh Plan or All-Savers Certificate. Regardless of this pledge, if payments on this loan are up-to-date, Borrower(s) can withdraw shares and/or deposits to the extent indicated on this form.

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Eduardo C. Abellana, MD 8735 Canterbury Lane #8 Newport 48166	— AN	Haitham M. Masri, MD— 2311 E. Stadium Blvd. Ann Arbor 48104	OTO/HNS
Sidney M. Broder, MD 302 Kensington Flint 48502	— N	John R. Novosad, MD 331 S. Michigan Big Rapids 49307	— AN
Nancy J. Brooke, MD 1901 Knapp, NE Grand Rapids	— AI/PD	William G. Nutting, MD 1637 Monroe Dearborn 48124	— U
Randall N. Clark, MD 1470 Peck Street Muskegon 49441	— FP	Mark D. Pearlman, MD 3231 Belle Court Royal Oak 48072	— OBS
Gordon T. Goodman, MD 2222 Fuller Rd. #412A Ann Arbor 48105	— N	Kathryn M. Rahn, MD 413 Third St. #6 Ann Arbor 48103	— P
Shaker H. Haddad, MD 12813 W. Warren Dearborn 48126	— PD	Jennifer S. Read, MD 2491 Lancashire #2A Ann Arbor 48105	— PD
Lawrence F. Handler, MD 43211 Dalcama Dr. #3 Mt. Clemens 48044	— OPH	Rajesh Kumar Sethi, MD Marquette Med. Center #222 Marquette 49855	— N
C. Jeffrey Holmes, MD 510 Prospect Street Alma 48801	— FP	Steven A. Sherman, MD 333 E. Jefferson #B Ann Arbor 48104	— N
Mark A. Jackson, MD 1213 W. Front Street Traverse City 49684	— FP	Rodman M. Taber, MD 3300 Burton, SE Grand Rapids 49506	— OBG
Scott Kaatz, DO 1010 W. County Rd. Grayling 49738	— IM	Mir Waziri, MD 1215 Michigan Avenue Lansing 48912	— NPM
N. David Lessani, MD 15555 S. Telegraph Rd. #9 Monroe 48161	— OBG	Silvana Yovanof, MD 900 E. Blvd., S. #G-27 Pontiac 48053	— IM
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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

Reference:

1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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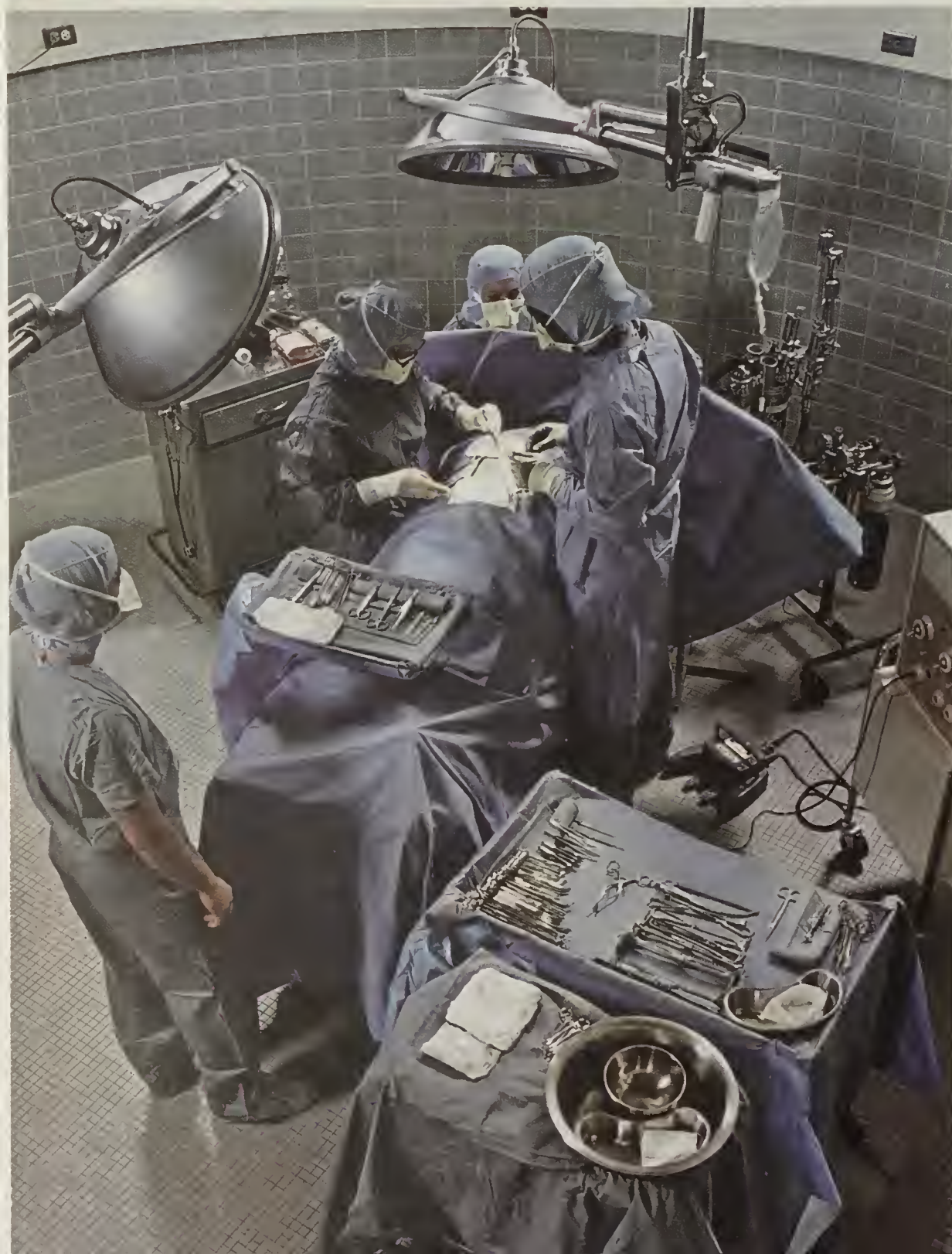
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DEATHS

Juan E. Alejos, MD Birmingham

Doctor Alejos, a Birmingham pediatrician, died Aug 10 at the age of 55. He was a graduate of Universidad National-San Marcos School of Medicine, Lima, Peru. He was chief resident at Children's Hospital, Birmingham, Ala. Doctor Alejos was secretary of the Michigan Chapter of the American Academy of Pediatrics, secretary of the Peruvian American Medical Society and president of the Detroit

Pediatric Society. Doctor Alejos was on staff at William Beaumont Hospital in Royal Oak and Troy, South Macomb Hospital, and Henry Ford Hospital.

William M. Flintoff, MD Grand Rapids

Doctor Flintoff, a board-certified family practitioner for 32 years, died August 8 at the age of 68. A graduate of the University of Michigan in 1952, he served his postgraduate training at St. Mary's Hospital in Grand

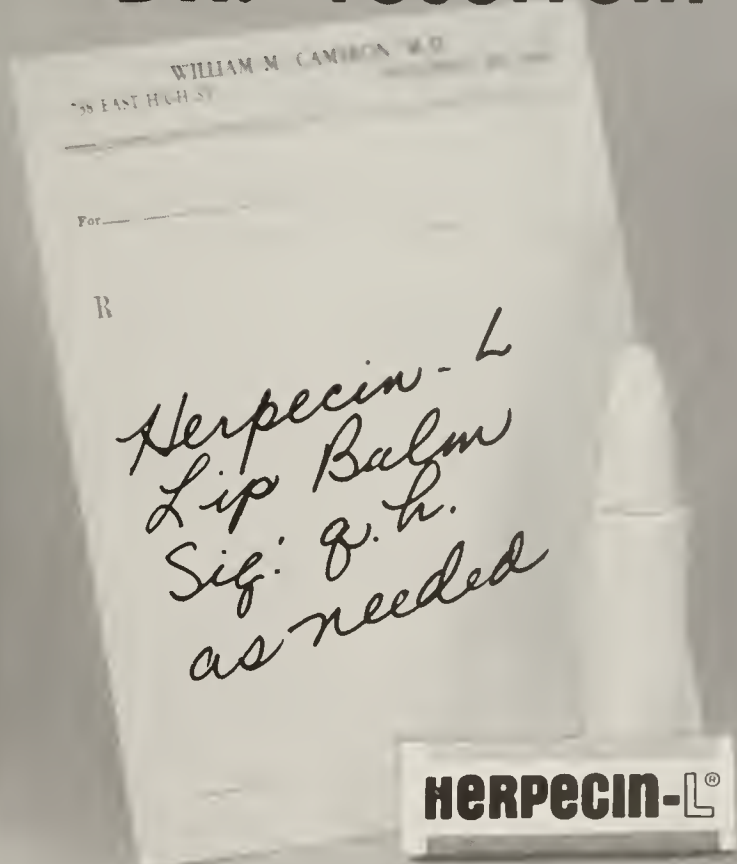
Rapids. Doctor Flintoff held a position as assistant clinical professor at Michigan State University's College of Human Medicine. He was a member of the American Medical Association and Kent County Medical Society.

Kenneth E. Gamm, MD Grand Rapids

Doctor Gamm died August 21 at the age of 80. A surgeon, he served on the staff of both St.

Continued on next page

Dx: recurrent herpes labialis



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DEATHS/Continued

Mary's Hospital and Blodgett Memorial Medical Center from 1947-1975. Doctor Gamm was a native of St. Paul, Minnesota and earned his medical degree from the University of Minnesota in 1931. He was a member of the American College of Surgeons, the American Medical Association, and the Kent County Medical Society.

Donald G. Hunter, MD Grosse Pointe Shores

Doctor Hunter, a Board-certified radiologist, died July 10 at the age of 66. A graduate of the Wayne State University in 1948, he underwent his internship at Grace Hospital, Detroit. Doctor Hunter served as captain in the US Army between 1954-56. He was a member of the American Medical Association, Oakland County Medical Society and the American College of Radiology.

John D. Littig, MD Kalamazoo

Doctor Littig, a retired Kalamazoo physician, died July 19 at the age of 85. A graduate of the University of Iowa in 1930, he served his internship at the University of Minnesota from 1930-1931 and his residency in internal medicine at the University of Michigan. He served as an instructor in internal medicine at the U-M from 1932-36, and was certified by the American Board

Continued on page 742

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DEATHS/Continued

of Internal Medicine in 1937. He was a member of the American Medical Association, and member and past-president of the following organizations: Kalamazoo Academy of Medicine, the Michigan Society of Internal Medicine and the Michigan Heart Association.

Clarence T. Pier, MD
Bradenton, Florida

Doctor Pier, a former Battle

Creek physician, died July 5 at the age of 83. A 1943 graduate of the University of Michigan Medical School, he practiced medicine for 26 years, retiring from the Battle Creek Veterans Administration Medical Center in 1969. He was a member of the American Medical Association and the Calhoun County Medical Society.

Edwin H. Terwilliger, MD
Bradenton, Florida

Doctor Terwilliger, a former

South Haven general practitioner, died March 19 at the age of 80. He was a 1934 graduate of Northwestern University Medical School and served his internship at Receiving Hospital, Detroit. He served as Lt. Col. in the US Army Medical Corps from 1941 to 1946. Doctor Terwilliger was past-president of Van Buren Medical Society where he also served as vice-president and secretary.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category 1 credit toward meeting the requirements of Michigan law. Sponsors of Category 1 programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category 1 credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

November

2, Fifth Annual Conference on Alcoholism and Other Drug Dependencies. Location: Genevieve U. and Donald S. Gilmore Center for Health Education, Kalamazoo. Sponsor: Gateway Villa, KADAC, Southwestern Michigan Area Health Education Center. Contact: Continuing Medical Education Department, Southwestern Michigan Area Health Education Center (616) 341-6360. Approved for: 6 hours Category 1 Credit.

3-4, Ear, Nose and Throat Practicum. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 19 hours Category 1 Credit.

3-4, Critical Clinical Issues in the Care of the Elderly: Reversing Critical Dysfunction. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School Geriatric Center, Division of Geriatric Medicine, Department of Internal Medicine, The University of Michigan Institute of Gerontology and Ann Arbor Veterans Administration Medical Center. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 14 hours Category 1 Credit.

11-12, 36th Annual Detroit Trauma Symposium. Location: Harper Hospital, Detroit. Sponsor: Wayne State University, Harper Hospital, Department of Surgery. Contact: Marjorie Norum, Department of Surgery, Harper Hospital, 3990 John R, Detroit 48201

(313) 745-2345. Approved for: 8.5 hours Category 1 Credit.

15, Behavioral and Medical Perspectives of Obesity and Eating Disorders. Location: Henry Ford Hospital, 2799 West Grand Blvd., Detroit. Sponsor: Henry Ford Hospital. Contact: Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 6.5 hours Category 1 Credit.

18, Psychiatry for the Primary Care Physician. Location: Henry Ford Hospital, 2799 West Grand Blvd., Detroit. Sponsor: Henry Ford Hospital. Contact: Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 6 hours Category 1 Credit.

20, Current Concepts in Urology: For the Primary Care Physician. Location: 12523 Third Avenue, Highland Park. Sponsor: Detroit Osteopathic Hospital. Contact: Sue Klomparnes, Detroit Osteopathic Hospital, Continuing Education Department, Detroit 48233 (313) 252-4823. Approved for: 7-1A hours Category 1 Credit.

30, Diabetes Mellitus: Sexuality, Pregnancy and Aging. Location: Fairlane Manor, Dearborn. Sponsor: Henry Ford Hospital. Contact: Office of Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313) 876-3072. Approved for: 7.5 hours Category 1 Credit.

December

4-5, The Difficult Airway. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical

School. Sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 13 hours Category 1 Credit.

7, Michigan Urological Society Socio-Economic Issues. Location: St. John Hospital, 22101 Moross Road, Detroit 48236. Sponsor: Michigan Urological Society. Contact: Robert DiLoreto, MD, 22151 Moross Road, -320, Detroit 48236 (313) 844-2244. Approved for: 4 hours Category 1 Credit.

9, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category 1 Credit.

10, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 7 hours Category 1 Credit.

January

13, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category 1 Credit.

14-15, Advanced Cardiac Life Support Provider Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Con-

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tinuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 16 hours Category I Credit.

29-2/3, The Thirteenth Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbour Springs. Sponsor: University of Michigan Medical School, Department of Family Practice with the Michigan Academy of Family Physicians, and Department of Postgraduate Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 20 hours Category I Credit.

February

10, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category I Credit.

11, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 7 hours Category I Credit.

10-12, Advanced Cardiac Life Support Instructor Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 21 hours Category I Credit.

13-17, Eighth Postgraduate Course on Myocardial Infarction and Angina Pectoris. Location: Convention Center, Davos, Switzerland. Sponsor: University of Michigan Medical School, Hanover Medical School, Hanover, West Germany. Contact: Karen McCalla, Marketing Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)

763-1400. Approved for: 28 hours Category I Credit.

27-3/3, Microvascular Workshop for Otolaryngologists and Head and Neck Reconstructive Surgeons. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery, and American Academy of Facial Plastic and Reconstructive Surgery. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 41 hours Category I Credit.

March

2-4, Advances in the Management of Infectious Diseases. Location: South Seas Plantation, Captiva Island, Florida. Sponsor: University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 12 hours Category I Credit.

14-18, Family Practice-1989 Thirteenth Annual Spring Review Course. Location: Towsley Center, University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Family Practice and the Michigan Academy of Family Physicians. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 34 hours Category I Credit.

22-23, 28th Annual Conference on Maternal & Perinatal Health: "Perinatal Periscope: Looking Beyond the Horizon." Location: Hyatt Regency Dearborn. Sponsor: Michigan State Medical Society. Contact: Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, 517-337-1351. Approved for 11 hours of Category I Credit.

MEETINGS

MSMS MEETINGS

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517) 337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

January

18, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

March

2, First Annual MSMS Young Physicians Section Meeting, Hyatt Regency Dearborn, contact: Linda Munson, MSMS Young Physicians Section, (517) 337-1351.

8, MSMS Board of Directors Meetings, MSMS headquarters, contact: William Madigan (517) 337-1351.

22-23, Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyond The Horizon," Hyatt Regency Dearborn, Contact: Sherry L. Fent, (517) 337-1351.

AMA MEETINGS

December

4-7, AMA Interim Meeting, Dallas, Texas, contact: AMA, 535 North Dearborn St., Chicago, IL 60610, (312) 645-4344.

MICHIGAN SPECIALTY/ SOCIETY MEETINGS

December

7, Michigan Urological Society Socio-Economic Issues, St. John Hospital, 22101 Moross Road, Detroit, contact: Robert DiLoreto, MD, 22151 Moross Road, #320, Detroit 48236 (313) 884-2244.

15, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

January

19, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

February

16, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

March

16, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

April

20, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

May

4-5, Michigan Chapter, American College of Surgeons Collier Competition and Annual Meeting, Sheraton University Inn, Ann Arbor, contact: Viola M. Heins, P.O. Box 950, East Lansing 48826-0950, (517) 337-1351.

NATIONAL SPECIALTY SOCIETY MEETINGS

November

12-16, American College of Allergists Annual Scientific Meeting, Westin Century Plaza, Los Angeles, CA, contact: American College of Allergists, 800 E. Northwest Highway, Suite 101, Mt. Prospect, IL 60056, (312) 255-0380.

December

3-8, American Academy of Dermatology Annual Scientific Meeting, Washington, DC, contact: American Academy of Dermatology, 1567 Maple Avenue, P.O. Box 3116, Evanston, IL 60204-3116, (312) 869-3954.

February

5-8, American Society for Parenteral and Enteral Nutrition: 13th Clinical Congress, Fontainebleau Hilton, Miami Beach, contact: A.S.P.E.N., 8605 Cameron Street, #500, Silver Spring, MD 20910 (301) 587-6315.

9-14, American Academy of Orthopaedic Surgeons Annual Scientific Meeting, Las Vegas, NY, contact: American Academy of Orthopaedic Surgeons, 222 S. Prospect, Park Ridge, IL 60068 (312) 823-7168.

24-3/1, American Academy of Allergy and Immunology Annual Meeting, Convention Center, San Antonio, TX, contact: American Academy of Allergy and Immunology, 611 E. Wells St., Milwaukee, WI 53202 (414) 272-6071.

March

2-5, American College of Nuclear Physicians Annual Scientific Meeting, Sheraton Bal Harbour, Bal Harbour, FL, contact: American College of Nuclear Physicians, 1101 Connecticut Avenue, N.W., Suite 700, Washington, DC 20036 (202) 857-1135.

19-23, American College of Cardiology Annual Scientific Meeting, Hilton Inn, Anaheim, CA, contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 (301) 397-5400.

19-24, American Association of Pathologists Annual Meeting, New Orleans, LA, contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814 (301) 530-7130.

April

2-6, American Association of Neurological Surgeons Annual Meeting, Washington, DC, contact: American Association of Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312) 692-9500.

4-6, American Laryngological, Rhinological and Otological Society Annual Scientific Meeting, Fairmont Hotel, San Francisco, CA, contact: The Triological Society, P.O. Box 155, East Greenvew, PA 18041 (215) 679-7180.

12-16, American College of Preventive Medicine Annual Scientific Meeting, Westin Hotel, Atlanta, GA, contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202) 789-0003.

13-16, American College of Physicians Annual Meeting, San Francisco, CA, contact: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104 (215) 243-1200.

13-19, American Academy of Neurology Annual Scientific Meeting, Hynes Convention Center, Chicago, IL, contact: American Academy of Neurology,

2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612) 623-8115.

29-5/5, American Occupational Medical Association Annual Scientific Meeting, Sheraton Boston, Boston, MA, contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312) 228-6850.

May

6-12, American Psychiatric Association Scientific Meeting, San Francisco, CA, contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005 (202) 682-6000.

7-10, American Association of Plastic Surgeons Annual Meeting, Camelback Inn, Scottsdale, AZ, contact: American Association of Plastic Surgeons, The John Hopkins Hospital, 601 N. Wolfe Street, Harvey 811, Baltimore, MD 21205 (301) 669-7601.

7-11, American Urological Association Annual Meeting, Infomart/Loews Anatole Hotel, Dallas, TX, contact: American Urological Association, 1120 N. Charles Street, Baltimore, MD 21201 (301) 727-1100.

8-10, American Association for Thoracic Surgery Annual Meeting, Sheraton/Hynes, Boston, MA, contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

13-17, American Society for Gastrointestinal Endoscopy Annual Scientific Meeting, Sheraton Hotel, Washington, DC, contact: American Society for Gastrointestinal Endoscopy, Thirteen Elm Street, Manchester, MA 01944 (617) 927-8330.

13-19, American Gastroenterological Association Annual Scientific Meeting, Sheraton Washington and Shoreham Hotels, Washington, DC, contact: American Gastroenterological Association, 6900 Grove Road, Thorofare, NJ 08086 (609) 848-1000.

14-17, American Thoracic Society Annual Scientific Meeting, Convention Center, Cincinnati, OH, contact: American Thoracic Society, 1740 Broadway, New York, NY 10019 (212) 315-8778.

22-25, American College of Obstetricians and Gynecologists Annual Meeting, Convention Center, Atlanta, GA, contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington DC 20024 (202) 638-5577.

28-31, American Pediatric Surgical Association Annual Meeting, Hyatt Regency Inner Harbor, Baltimore, MD, contact: American Pediatric Surgical Association, Johns Hopkins Hospital, Baltimore, MD 20105 (301) 955-6256.

OTHER MEETINGS

November

16, Obesity in Children: Assessment and Management, Kellogg Center for Continuing Education, Michigan State University, East Lansing, contact: College of Human Medicine, Michigan State University, East Lansing 48824, (517) 353-4876.

17-18, NIMH AIDS Training Program for Health Care Providers, McGregor Memorial Conference Center, Wayne State University, contact: NIMH AIDS Training Program, 5454 Cass Avenue, Room 210 Nursing Annex, Detroit 48202 (313) 577-5731.

December

5-6, NIMH AIDS Training Program for Health Care Providers, McGregor Memorial Conference Center, Wayne State University, contact: NIMH AIDS Training Program, 5454 Cass Avenue, Room 210 Nursing Annex, Detroit 48202 (313) 577-5731.



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POSITIONS OPEN

EMERGENCY DEPARTMENT PHYSICIAN. The Pontiac General Hospital emergency department is under new management with a new medical director. We are seeking full-time, committed, professional emergency department physicians who are Board Eligible or Board Certified. New contractual situation with expanding group will offer outstanding growth possibilities with top hourly compensation and profit sharing. Send CV to Timothy Molyneux, Recruiting Manager, The Sterling Group, 119½ West Indiana Avenue, Perrysburg, Ohio 43551, or call (419) 874-4053.

LAPEER, MICHIGAN. Seeking full-time and part-time emergency department physicians for busy 164-bed hospital. Residency training in emergency medicine or primary specialty required. Excellent compensation and attractive schedule. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc., Room 23, 2240 South Airport Road, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

EMERGENCY PHYSICIAN NEEDED to staff moderate volume Emergency Department in Southwest Michigan (18,000—22,000 visits per year). Full sub-specialty backup. Flexible schedule. Prefer previous experience or Board Certification. Reimbursement competitive and benefits including membership into Corporation are negotiable. Please send resume to: Emergency Physicians, P.C., 5916 Oakland Drive, Kalamazoo, MI 49002 or call (616) 963-5048.

RADIOLOGIST POSITION AVAILABLE starting 1-1-89. Located in western suburb of Detroit, must be Board certified in diagnostic radiology. Income and fringe benefits negotiable. Send CV to Box 129, *Michigan Medicine*, P.O. Box 950, East Lansing, MI 48826-0950.

ORTHOPEDIC SURGEON. A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible orthopedic surgeon to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

PSYCHIATRIST. A progressive 131-bed two-

hospital system is seeking a Board certified or Board eligible psychiatrist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

DERMATOLOGIST. A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible dermatologist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

NEUROLOGIST. A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible neurologist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

EMERGENCY ROOM PHYSICIAN. A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible emergency room physician to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

OPHTHALMOLOGIST: Needed for busy, multi-site practice in Metro Detroit area. Supportive technical and administrative staff. Well equipped offices. Large referral network. Unique opportunity, excellent salary, liberal fringe benefits. Full or part-time positions available. Confidential contact: Margaret Roze (313) 283-0500.

BOARD CERTIFIED/BOARD ELIGIBLE OB/GYN or family practice with OB experience for association in a growing practice. Partnership after one year. Good living area, close to Detroit. Call

(313) 329-7056, ask for Pat.

ANN ARBOR, MICHIGAN. BE/BC family practitioner, pediatrician or combined Ped/Int Med., full or part time, needed to join a primary care multi-specialty private practice. Please send CV, with cover letter, to Box 7351, Ann Arbor, Michigan 48107.

ANN ARBOR. Elderly internist seeks associate for excellent busy Internal Medicine practice to assume full practice after one to two years. Excellent facilities. Opportunity for academic affiliation. Write *Michigan Medicine*, P.O. Box 950, Box 127, East Lansing, MI 48826-0950.

GENERAL SURGEON. Three-man surgical group looking for an associate. Candidates should be able to do general and vascular surgery and have additional training or experience in endoscopy. Michigan community of 37,000 with excellent schools, recreational opportunities and cultural activities. Modern 300-bed hospital with full range of specialty services. Please reply to: *Michigan Medicine*, P.O. Box 950, Box 120, East Lansing, MI 48826-0950.

INTERNIST, BE/BC with subspecialty in Rheumatology to join a 40-member multispecialty group in the Midwest. Excellent referrals. Fee for service with a guaranteed draw for the first two years. Located within 70-150 miles of Indianapolis, Chicago and St. Louis. Send CV or contact: Dr. Pagan or Dr. Janicki, Associated Physicians & Surgeons Clinics, 221 South Sixth Street, Terre Haute, Indiana 47807, (812) 232-0564.

MICHIGAN—MEDICAL COMMUNITY SEEKING additional pediatricians. Coverage available; several practice options. Hospital has well-equipped nursery, 20-bed pediatric unit, and enthusiastic staff. Interest in neonatology a plus. Located near universities. Growing area has solid economic base and offers many cultural activities. Contact Rebecca Turley, 1-800-338-7107, or send CV to: Fox Hill Associates, Ltd., 250 Regency Court, Waukesha, Wisconsin 53186.

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NEUROLOGY. SEI HEALTH SERVICES is seeking two adult neurologists for a large neurological group in the Southeastern United States. Recruiting Board-eligible or Board-certified physicians. Competitive salary and comprehensive benefit package that includes malpractice insurance and relocation assistance. Clinical experience in EEG, EMG, evoked response, doppler ultrasound, and sleep disorders preferred. Send resume to: SEI Health Services Division, James Hacker, General Manager,

Continued on next page

CLASSIFIED/Continued

7725 Little Ave., Charlotte, NC 28226, or call: (704) 542-7100.

PEDIATRICS. MARSHFIELD CLINIC, a 270-physician, multispecialty private group practice, is seeking a board certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to: Mr. David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or you may call collect at (715) 387-5376.

NORTHERN MICHIGAN MEDICAL CORPORATION seeking internal medicine physicians. Well-established family practice with 90+ bed hospital with various specialties available. Four medical clinics. Small town atmosphere. Very nice retirement and vacation area. Negotiable salary and opportunity to become corporate shareholder. Reply to: Edna Rydd/Business Manager, Corporate Office, P.O. Box 509, Rose City, MI 48654. (517) 685-3366.

SOUTHWEST MICHIGAN COASTAL COMMUNITY: General internist to join another general internist's growing practice. Desirable area with excellent schools, recreational opportunities, and cultural activities. Modern well-equipped, 332-bed hospital a few blocks from the clinic. Competitive first year guarantee and benefit package. Contact Bob Strzelczyk, 12724 N. Maplecrest Ln., Mequon, WI 53092, 1-800-243-4353 or (414) 243-9500 (collect in Wisconsin).

OPPORTUNITY OPEN FOR A PHYSICIAN to work with a phlebologist MD at Vein Clinics of America in the affluent Detroit suburb of Birmingham. Please call if you are interested in a new method for treating varicosities by injection. Call weekdays 9 am—5 pm. (313) 642-0210. Call week-day evenings 7-8pm (313) 445-5638.

FULL TIME, PART TIME AND LOCUM TENENS. GPs, PPS and Emergency Physicians needed to staff a network of convenience medical care centers located in Bay City, Saginaw, Midland and Mt. Pleasant, Michigan. Flexible hours and attractive compensation packages. Send CV to, or contact Euclid Medical Group, PC, 1420 Center Avenue, Bay City 48708, (517) 892-1199.

FAMILY PRACTITIONER AND INTERNAL MEDICINE SPECIALISTS to join seven-doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First-year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact: John

Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

PEDIATRICIAN — ANN ARBOR. Pediatric Urgent Care/Emergency seeking F/T or P/T pediatrician, available immediately. Evenings and weekends required. Require BC/BE pediatrician. APLS skills and skills in managing acutely ill and injured infants and children necessary. If interested, please contact or send CV to Recruiting Department, Emergency Physicians Medical Group, Inc., Sparrow Wood Office Center, 2864 Carpenter Road, Suite 100, Ann Arbor, MI 48108, 313-973-7622.

PRACTICES FOR SALE

GENERAL PRACTICE AVAILABLE: Belleville, Trenton, Drayton Plains, South Oakland County, Southfield, Warren and Royal Oak Vicinity, Allen Park and Mt. Pleasant. Call Herbert Silverman, Associate Broker, (313) 569-7336. Professional Practice Sales, Inc., 27208 Southfield, Lathrup Village, MI 48076.

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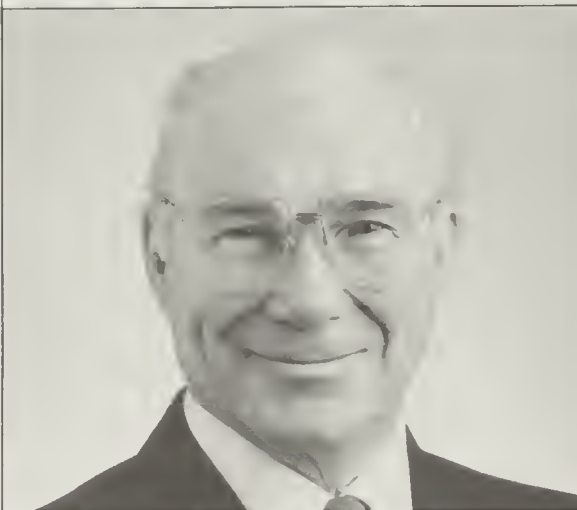
Observations of an innocent at the AMA

By Fred W. Bryant, MD

Middlin' in size compared to the mega and mini states, Michigan's Delegation to the AMA is one of the best; it has a fine reputation for involvement, quality and honorable conduct. At present we have 22 representatives, 11 delegates and 11 alternates. All are top-drawer performers, experienced in local and state affairs. Twice yearly, on the occasions of the Annual and Interim sessions of the AMA House, the Delegates burst forth in a frenetic week of enthusiastic industry, working ceaselessly — literally from dawn to dusk — on a schedule chock-full of defined duties and assignments.

I, too, am a member of the Delegation by virtue of my position as president of MSMS. For the most part, I have no specific assignment. Footloose in the center of this huge universe of activity, I watch my fellows fit into the serial progression of events and procedures and witness the drama and suspense which somehow occurs in every session. I will recount some of my observations, not to be considered all-encompassing.

The AMA faces the issues and usually responds squarely and head-on. It has the capacity for introspection, to turn inward and examine itself and its members (often in a fishbowl of public scrutiny). Yet, it is extroverted too, lecturing to the nation in clarion tones, probably the strongest voice in the health community.



Doctor Bryant

The AMA abounds in notables and personalities. There is a procession of illustrious officers and a large royal family. Even then, unique and extraordinary individuals stand out. Jim Sammons, AMA executive vice president, is an example par excellence of efficiency and universality at its best, a stabilizing force within the AMA.

Michigan, too, has illustrious people. Donald K. Crandall, MD, chairs the AMA Council on Medical Service. Thomas R. Berglund, MD, headed AMPAC. Richard L. McMurray, MD, former leader of the Michigan Delegation, now serves on The Council on Judicial and Ethical Affairs. And, of course, one of our members made it to the top. John J. Coury, MD, served as AMA president in 1986 after first having been elected to the AMA Board of Trustees in 1976.

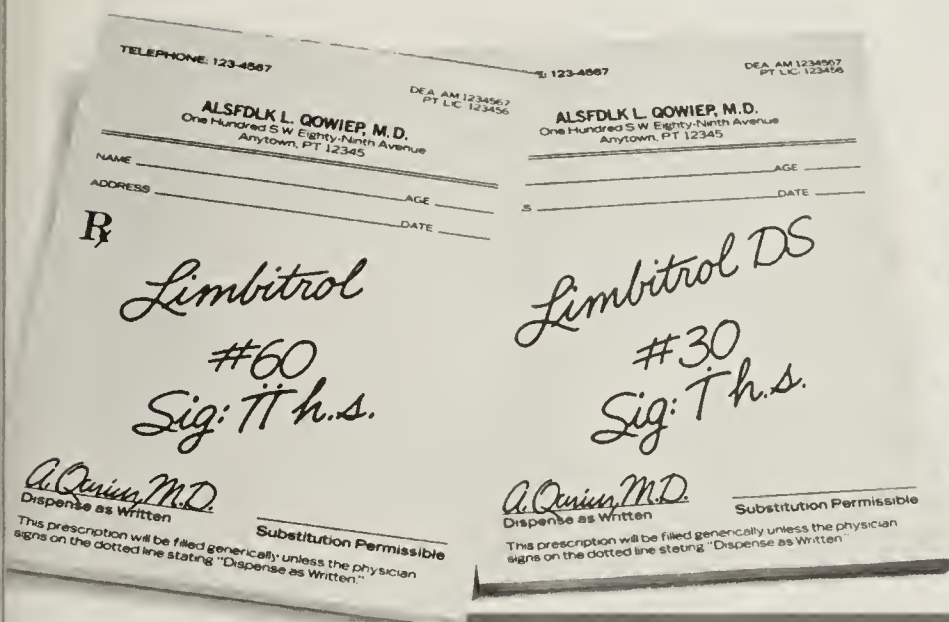
Regeneration of Michigan ambitions recently took place. Frank B. Walker, MD, chairman of the

MSMS Board of Directors, chairman of the Michigan Delegation to the AMA, and a Long Range Planner for the AMA, recently won a seat on the AMA Board of Trustees. He joins a select baker's dozen of others on this important central body. And Peter A. Duhamel, MD, of our Michigan Board of Directors, was selected treasurer of the AMA Hospital Medical Staff Section. And so, the parade goes on.

Not every one belongs to the AMA — or even endorses it. But somehow this giant in our midst is bigger than any of us alone, or in any combination less than itself. We need this added dimension at the top, to see the grand vista and to be seen. We need the strength and authority of this powerful arm and the timber and resonance of its strong voice. This is as close to unity as we get. Sometimes things are best done on a grand scale. We need the AMA and it needs us! □

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Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

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Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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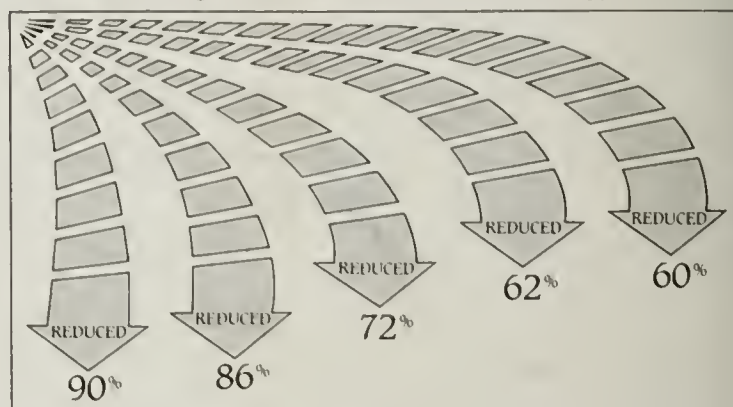
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DECEMBER 1988

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Vol. 87, No. 12

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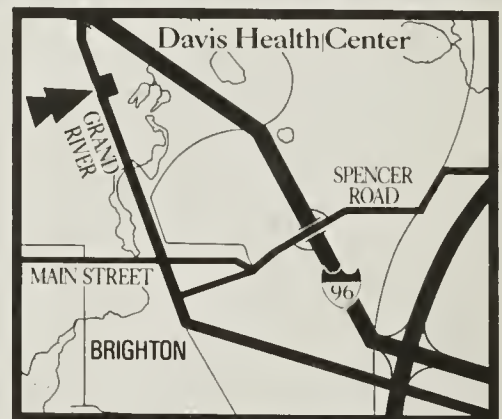
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M I C H I G A N MEDICINE

DECEMBER 1988 Vol. 87, No. 12

Special Report

MSMS continues to emphasize the important role education plays in the fight against AIDS, as, at present, prevention is the only way to defeat the deadly disease. This month's special report features three articles that weave together the many AIDS education activities sponsored by MSMS in 1988. Following an introduction by MSMS President Fred W. Bryant, MD, appears a recap of a one-hour national perspective on AIDS given by James Curran, MD, AIDS program director, Centers for Disease Control, Atlanta, at the MSMS Annual Scientific Meeting in November. Also featured is an overview of the third update session of the MSMS AIDS Speakers Bureau, also held in November. Finally, the results of a special survey of Michigan physicians regarding their attitudes about AIDS concludes the report.

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By Fred W. Bryant, MD 814

In next month's issue of *Michigan Medicine*:
A complete preliminary program of the 28th Annual Michigan Conference on Maternal and Perinatal Health to be held March 22-23 at the Hyatt Regency Hotel in Dearborn.

Cover photo by: Kim Kauffman

Can physicians 'risk' avoiding risk management?

By Thomas R. Berglund, MD

Risk management may not prevent lawsuits, but it can function as an insurance policy for a medical career.

Medical risk management involves predicting, preventing and controlling risk while planning and providing appropriate care.

Here are some reasons physicians should be involved:

1. Medicine never has been, and might never be, an exact science. A bevy of clinical problems can pre-exist or surface. Risk management can help anticipate or preclude them.

2. Expectations of positive medical care outcomes have reached new heights. It's important to prepare for and mitigate misguided fault-finding and liti-

Doctor Berglund is president and chairman of MPMLC, and is a member of the MSMS Committee on Publications.



Doctor Berglund

gation.

3. The concept of a good "bedside manner" has evolved to far-reaching proportions. Non-clinical issues trigger attitudes that can be fired off in disarming and troubling legal salvos regardless of a practitioner's noble intent or heroic effort.

4. There are "malpractice-prone" patients and physicians.

Patients can be excessively anxious, irrational, suspicious and paranoid. Physicians might be insecure, uncertain, yet unable to identify and work within their limitations.

5. Complexities abound and it's difficult to balance intricacies associated with patient communications, informed consent, medical records, referrals, consultations, confidentiality, terminating a patient relationship and a wide array of legal and moral considerations. Risk management services can guide and assist physicians through this maze of issues.

The Michigan State Medical Society created Michigan Physicians Mutual Liability Company (MPMLC) during the liability crisis of the mid-1970s. MPMLC

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The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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Cooperation is the key to solving rural physician shortage

In your Special Report on rural physicians in Michigan, printed in the August issue of *Michigan Medicine*, you described in detail the rural physician shortage in Michigan. At the conclusion of the article, recommendations for resolving this problem were given.

Recommendation number one suggested the "development of a rural primary care curriculum for medical students." In 1974, the College of Human Medicine at Michigan State University and the Upper Peninsula Health Education Corporation established the Upper Peninsula Medical Education Program. The Program was created to address the physician shortage in the rural Upper Peninsula. Medical students in the program complete their first two years of study on the campus at Michigan State University and then move to the Upper Peninsula. During their third year students complete a special seven-month rotation in Escanaba in primary care medicine, which is essentially ambulatory in nature and consists of clinical rotations in family practice, pediatrics, general internal medicine, psychiatry and obstetrics and gynecology. Our students take a great deal of responsibility for patient care as a result of the close working relationship that our low student to preceptor ratio allows. Studying this



way affords students the opportunity to experience over a considerable time a medical practice in a rural environment.

Year four of their training takes place at Marquette General Hospital where students complete hospital-based rotations in surgery, internal medicine and psychiatry. Marquette General Hospital is a regional medical center which offers the students experiences in caring for critically ill patients. As a result of their training in both environments, students are able to make informed decisions about where they would prefer to practice.

In a follow-up study of the graduates of the program who are currently practicing, it was found that 50 percent of the physicians trained in the UP program are practicing in rural areas throughout the US. Sixty-five percent of the graduates were practicing in primary care specialties (general internal med-

icine, obstetrics and gynecology, family practice and pediatrics) and 47 percent of them were family practitioners. This represents an impressive improvement over national figures which show that thirteen percent of US physicians practice in rural areas. Nationally, thirty-five percent of US physicians eventually have primary care practices and about thirteen percent of the total number of medical school graduates enters family practice each year.

Positive medical school experience is the key

According to the responses of the graduates to the follow-up study questionnaire, there are many factors that influenced their decisions about where to practice. The program admits students from rural areas who express an interest in primary care, as studies have shown that people from rural areas are more inclined to practice in rural areas than those from urban areas. A majority of Upper Peninsula graduates reported that their experience in a rural medical school convinced them that they would prefer to practice in that environment. Unlike most medical school curricula, the Upper Peninsula curriculum includes a two-month rotation in family practice. Sixty-one percent of the UP graduates reported that they chose a primary care specialty because they had a positive medical school experience in family practice.

Continued on page 796

Thinking beyond the numbers: AIDS education and our mission

By Fred W. Bryant, MD

Most reports on AIDS begin with a discussion on statistics. This month's special report on AIDS will not. This is not because the numbers are insignificant, but because sometimes they cease to communicate their significance to us.

This month's special report in *Michigan Medicine* will focus instead on the seemingly less "monumental" trends in our workplaces, schools and hospitals — for it is here that some of the greatest energy is being put forth to control the growth of AIDS cases. It is here, also, that individuals are reaching out to those who have contracted the virus and are dispelling their own private fears about AIDS.

If we look closely at these trends in community-based programs, we can see that we are not alone in the struggle against fear and ignorance. We can learn ways to overcome these twin obstacles. Our communities can reach out to people with AIDS and devise effective forms of support.

Our mission as health care professionals should be to encourage our colleagues, knowing that each positive step will contribute to the solutions and will have an impact. We need to involve each other in this task and engage in dialogue that leads to consensus on how to approach the problems presented by AIDS.

Among the issues that need to be thoroughly dealt with is the terror of social penalty that confronts people with AIDS, the stigma and rejection that, aside from the devastation of the illness itself, contribute much to the complexity and controversy surrounding the disease.

We have made some real progress within the medical professions in recognizing and dealing with the consequences — for our patients — of an HIV-positive diagnosis. But we must also communicate what experience is teaching us.

At present, the AIDS Education Project is the focal point and key response of the Michigan State Medical Society to the AIDS crisis. The MSMS AIDS Speak-

ers Bureau offers speakers to health care professional groups. The Professional AIDS Telephone Information Network is a tremendous resource for physicians and other health care workers with questions regarding AIDS.

In the following special report you will find three articles that weave together the last of many AIDS activities sponsored by MSMS during 1988. These activities were achieved with the assistance and involvement of many dedicated Michigan physicians.

At the November 1988 MSMS Annual Scientific Meeting in Dearborn, more than 100 physicians listened to James Curran, MD, AIDS program director for the Centers for Disease Control in Atlanta, who offered a one-hour national perspective. He encouraged Michigan physicians to continue to work together to advance the present methods of treating and counseling patients with AIDS. A full report on his presentation appears on page 759.

An overview of the third update session of the AIDS Speakers Bureau, also held in November, appears on page 761.

Finally, the results of a special survey of Michigan physicians, beginning on page 763, concludes the report — and the Society's AIDS activities for 1988. This survey, which began in early 1988, was conducted as a means to learn how physicians were reacting and responding to information about AIDS. One of the most encouraging findings was the resounding number of physicians — 80 percent — who said they felt no reluctance to treat AIDS patients.

Because of the unity and consensus we have encountered during the past year, the MSMS AIDS Education Project will initiate other actions on other fronts in the campaign against AIDS in 1989, especially in the field of public education. Your support has enabled us to begin — and to continue — to assist Michigan's diverse communities in dealing with the AIDS crisis.

Doctor Bryant is the chairman of the MSMS AIDS Provider Education Task Force.

Doctor Curran: 'AIDS is a truly American problem'

By Chad B. Munger

By the year 1992, AIDS will be the second leading cause of death for people under age 65, according to James Curran, MD.

"It's the only cause of premature death that is going up," the AIDS program director, Centers for Disease Control, Atlanta, told physicians attending the first-ever "Early Bird" Plenary Session at the MSMS Annual Scientific Meeting in November.

An AIDS expert, Doctor Curran is well aware that the conundrum of the disease extends far beyond its clinical aspect. "AIDS is a challenge to social skills as well as to medical skills," he said.

The social stigma of AIDS is not a problem reserved exclusively for its host. It also is a major obstacle for all those people who devote themselves to research and treatment of the disease, according to Doctor Curran. AIDS is now an issue in the physician/patient relationship regardless of the reason for a particular patient's interaction with a physician.

"Often people ask whether or not you treat AIDS patients," said Doctor Curran. Questions like this, he said, are a reflection of the ignorance and deep-rooted fear that surround the AIDS issue. They segregate doctors and patients into two groups — those who treat (or have treated) AIDS patients and those who do not, Doctor Curran pointed out.

"He who knows AIDS, knows medicine," Doctor Curran said. He acknowledged, however, that that is not a philosophy that is shared by all his peers.

"One of the things we (physicians) need to do to get AIDS under control is to get more physicians involved," Doctor Curran said. He added that, "The decision of whether or not to treat AIDS patients is colored by the knowledge that associating your name with AIDS professionally can mean the loss of a portion of your patient caseload."

Three key problems with AIDS

For those who do decide to deal with AIDS, the problems associated with the disease only get worse, Doctor Curran said. The most immediate problem physicians face regarding AIDS, according to Doctor Curran, is the clinical nature of the disease itself.

"AIDS is really the first retrovirus ever to enter the



"One of the things we (physicians) need to do to get AIDS under control is to get more physicians involved," said James Curran, MD, AIDS program director, Centers for Disease Control, Atlanta, at the MSMS Annual Scientific Meeting in November.

human population," Doctor Curran explained. "Only a decade ago the technology used to investigate the life-history of the HIV virus and the mechanisms that make it so destructive were not available. Fortunately such technology is in place at this time and there is hope for understanding how the virus works and how it can be stopped. But to accomplish these things there must be a change in perspective on the part of a large number of people in the United States, including many physicians."

Long-term incubation

In terms of perspective, Doctor Curran said "The first problem is that AIDS is a long-term problem and must be treated as such. We must change the acute disease and treatment mentality that exists today."

The length of time required for a disease to develop seems to have a significant impact on how successfully the disease is treated, Doctor Curran continued.

"In the United States we do well with short-term medical problems — diseases that have short incubation times and quick fix treatments," he said. "Diseases with long incubation periods like lung cancer or moderate incubation periods like AIDS are generally not treated as successfully."

Continued on next page

The author is a staff intern, MSMS Department of Communications and Professional Relations.

DOCTOR CURRAN/Continued

Sex

Sex is the second obstacle or problem physicians must overcome in dealing with AIDS, according to Doctor Curran. "Frank discussion of human sexuality has never been a hallmark of American society or of the American physician," he noted. "Unfortunately, open sexual dialogue between individuals and between physicians and their patients is fundamental to the treatment of AIDS. Only as discussion of sex becomes more acceptable and more prevalent will the spread of the disease be curbed."

An unpleasant disease

The third problem regarding AIDS, according to Doctor Curran, is that AIDS is "not a pleasant disease to deal with."

"But deal with it we must." Due to the lethal nature of this disease and to the media's eagerness to grab

"AIDS is a truly American problem. The fact that more AIDS cases have been reported in the New York state prison system than in all of Great Britain, is a dying testament to this."

onto a story which has the potential for mass tragedy or for exposing the sex lives of any number of well-known people, AIDS will be written and talked about more than any other health issue of our time, Doctor Curran said.

"Media coverage is a double-edged sword for the AIDS epidemic. On the one hand, information and exposure of the problem are desirable and will be instrumental in prevention of the disease. On the other hand, media often concentrate on the sensational stories that have the potential to spread misinformation and produce unnecessary concern."

"The media tend to relate more to the death of Rock Hudson than to a new breakthrough in medical technology," he continued. "In any event, the preponderance of information that is centered on the AIDS issue will at least keep it on the public's mind."

Exactly what the public does know about AIDS is not clear, according to Doctor Curran. "There are a large number of misconceptions surrounding AIDS — ideas such as: 'I can get AIDS from giving blood.' "

Misconceptions about AIDS are juxtaposed with a high degree of knowledge about some aspects of the disease, according to Doctor Curran. "It is estimated that 98 percent of the US population is aware that AIDS can be transmitted through sex or the use of needles," he said.

Exactly who knows about AIDS is not known, said Doctor Curran. What is known is which people are at the greatest risk of contracting the disease.

In the last eight years nearly 70,000 cases of AIDS have been reported in the United States. Of these nearly half have been reported since 1987.

The US Public Health Service projects that by the end of 1992, cumulative AIDS cases will total 365,000, with total deaths due to AIDS projected to reach 263,000. Also by 1992, the Public Health Service projects the cost of treating AIDS patients will fall between \$5 billion and \$13 billion.

An American problem

"AIDS is a truly American problem. The fact that more AIDS cases have been reported in the New York state prison system than in all of Great Britain, is a dying testament to this," said Doctor Curran.

"Every American is at risk, and the statistics are endless. AIDS in the heterosexual population is on the rise, up from one percent of the total cases reported in 1982 to 2.9 percent this year. Hispanics and blacks show a rate of AIDS acquisition two to 18 times higher than white populations." (This is thought to be due to higher reporting rates of IV drug abusers and their sexual partners in these populations.)

Possibly the most disturbing recent news, according to Doctor Curran, is that women from all backgrounds are showing up as AIDS carriers. This group is at extreme risk of passing AIDS onto their children by parenteral transfusion.

The message is that you don't have to be homosexual or an IV drug abuser to get AIDS, or to give it to someone else, Doctor Curran concluded. □

AIDS Speakers Bureau — activities update

By Lisa Strother
Coordinator, MSMS AIDS Education Project

More than 75 health care professionals attended the third update session of the AIDS Speakers Bureau in Lansing last month. Three-fourths of the Bureau's members, they reflect the continuing commitment and dedication of participants in the Bureau to educate health care professionals in our state about AIDS.

The outstanding contributions of these individuals to the cause of AIDS education through the Speakers Bureau program has enabled us to hold 250 educational seminars for a total of 17,000 health care providers throughout the state since October 1987. These figures offer encouragement and hope as we fight to control a disease that presently can be defeated only through prevention.



Evelyn Fisher, MD, of Henry Ford Hospital, informed members of the MSMS AIDS Speakers Bureau of the risk assessment and counseling components that should be inherent in every consideration of HIV testing.

At the update session with the latest information in AIDS prevention were a number of Michigan's foremost AIDS experts. Speakers and topics for the session included:

— **Fred W. Bryant, MD**, MSMS president and chairman of the MSMS AIDS Provider Education Task Force, who served as moderator and host of this day-long event.

— **Randall Pope**, chief of the Special Office on AIDS Prevention, MDPH, who offered a progress report on MDPH activities and policies.



Kay Felt, attorney, Dykema Gossett, Detroit, provided members of the MSMS AIDS Speakers Bureau with a comprehensive overview of the legal issues surrounding AIDS.

— **Eve Mokotoff, MPH**, epidemiologist and also from MDPH, who presented the need for accurate reporting procedures in Michigan.

— **Mary Anne Ford**, chief of state government affairs, MSMS, who offered a status report on the evolving AIDS legislation under consideration in Michigan.

— **Kay Felt**, attorney, Dykema Gossett, Detroit, who gave a comprehensive overview of the legal issues surrounding AIDS such as access to care, HIV testing, consent prior to testing, and confidentiality. Also addressed was employment surrounding AIDS, specific to the concerns of health care institutions and individual health care workers. Copies of Kay Felt's presentation are available to MSMS members. Simply contact the MSMS AIDS Education Project at 517-337-1351. (An article based on Kay Felt's presentation on the legal issues of AIDS will appear in *Michigan Medicine* in 1989.)

— **Evelyn Fisher, MD**, of Henry Ford Hospital's Department of Internal Medicine, who addressed some clinical issues, including the risk assessment and counseling components that should be inherent in every consideration of HIV testing.

— **Judene Bartley, MPH**, director of Hospital

Continued on next page

AIDS SPEAKERS BUREAU/Continued

Epidemiology, Harper-Grace Hospital, who discussed the latest state and national requirements for universal precautions.

— **Lawrence Crane, MD**, section chief, Infectious Diseases, Harper-Grace Hospitals, who provided care and treatment options for HIV-infected patients.

— **Abby Rosenthal**, of the Greater Detroit Area Health Council, who concluded the program by leading a panel discussion of the AIDS resource options available to AIDS patients and their families. Panelists **Scott Walton**, executive director of Wellness Networks Inc., and **Kevin Seitz**, director, Michigan Department of Social Services, suggested possibilities health care professionals should consider to augment patient care.

MSMS members who are developing AIDS education programs, or who are aware of health organizations in need of sponsored speakers, are encouraged to contact the MSMS AIDS Education Project at (517) 337-1351. □



Attendees at the third update session of the MSMS AIDS Speakers Bureau take a moment during break to review resource materials available to them through the Bureau. Resources include slides, videotapes and printed materials.

**MSMS AIDS Telephone
Information Network
1-800-522-0399**

MDPH renews grant to MSMS for AIDS Education Project

The Michigan Department of Public Health renewed its grant to MSMS October 1, marking the beginning of the third year of the AIDS Provider Education Project.

With the new grant, MSMS will continue its operation of the popular AIDS Speakers Bureau and of the AIDS Telephone Information Network.

New projects will include speakers training, improved audio-visual materials, production of two AIDS manuals (one for physicians and one for other health care workers), "target AIDS" training programs for primary care physicians, and a meeting of the AIDS Provider Education Task Force.



MSMS Executive Director William E. Madigan signs an agreement between MSMS and the Michigan Department of Public Health which calls for the continuation of the MSMS AIDS Provider Education Project.

Physicians' attitudes about AIDS vary, MSMS survey reveals

By Rose B. Heald
MSMS Chief, Health Care Programs

There are now over 77,078 diagnosed cases of AIDS in the US, a 50 percent increase in the number of cases found only six months ago. Nearly half of the nation's cases are found in only two states—California and New York.

Michigan maintains about one percent of the total, or currently, about 842 cases. However, experts estimate that by 1991 the number of AIDS cases in Michigan will reach 3,000, with 15,000 to 40,000 individuals infected with HIV.

An analysis of a Michigan State Medical Society survey of Michigan physicians' attitudes toward the disease, conducted in May 1988, was recently completed. The objective of the survey was to determine how physicians feel about caring for the state's AIDS patients, as well as their overall awareness of AIDS issues.

MSMS sent surveys to 600 randomly-selected physicians in 14 surgical and nine non-surgical specialties including family and general practice, internal medicine, immunology, infectious diseases, emergency medicine, general surgery, gynecology, neurology, orthopaedics and neurology. A response rate of 37 percent was realized. Demographic breakdowns by age, specialty and geographic location were analyzed. Geographic location contrasted southeastern Michigan—comprising Wayne, Oakland, Macomb and Washtenaw counties—with the remaining outstate counties.

Experience with HIV positive patients

Overall, 40 percent of respondents indicated they had seen HIV positive patients in their practices. It is interesting to note, when broken down by age, a direct correlation emerged between the age of the physician and the number of HIV positive patients the physician had seen. The younger the physician, the more HIV positive patients the physician had seen.

Not surprisingly, physicians in southeastern Michigan reported seeing HIV positive patients in their practices more frequently than did physicians in other areas of the state—53 percent compared to 42 percent. In addition, 38 percent of surgery specialists reported seeing HIV positive patients compared to 52 percent of non-surgery practitioners.

Frequency in ordering HIV antibody tests

Physicians in southeastern Michigan have ordered HIV antibody tests somewhat more frequently than have out-

Have you seen HIV+ patients in your practice?

Age	Yes	No
30-40	52%	46%
41-50	44%	51%
51-60	37%	61%
> 60	27%	73%

Geographic Location	Yes	No
Outstate Counties	42%	56%
Detroit Area	53%	43%

Specialty	Yes	No
Non-surgery practitioners	52%	46%
Surgery specialists	38%	61%

*Do not equal 100% because some respondents did not answer all questions.

state physicians. Sixty-nine percent of southeastern Michigan physicians reported ordering one to 10 tests, compared with 59 percent of outstate physicians. In addition, only 17 percent of southeastern Michigan physicians and 27 percent of outstate physicians have never ordered such a test.

Seventy percent of physicians over age 60 have ordered one to 10 HIV antibody tests compared to only 57 percent of physicians aged 30 to 40. Differences between surgical and non-surgical practitioners is much less marked: 65 percent of surgery specialists compared to 63 percent of non-surgery practitioners have ordered one to 10 tests. However, 19 percent of non-surgery practitioners compared to 29 percent of surgery specialists reported never ordering the antibody test.

Testing physicians for HIV

A rather wide variance was reported between surgery specialists and non-surgery practitioners in their responses

Continued on next page

SPECIAL REPORT

AIDS SURVEY/Continued

to the appropriateness of testing physicians for HIV infection. Sixty-two percent of surgeons compared to 47 percent of non-surgery practitioners believe that physicians should be tested for exposure to HIV. The difference narrows when comparing geographic locations: 51 percent of southeastern Michigan physicians believe testing is appropriate compared to 57 percent of outstate physicians.

Physician attitudes towards the appropriateness of testing physicians for HIV infection varies with age, but along somewhat mixed lines: 48 percent of physicians aged 31 to 40 believe it is appropriate as do 53 percent of physicians aged 41 to 50 and 63 percent of physicians

Should physicians be tested for HIV infection?

Specialty	Yes	No
Surgeons	62%	36%
Non-surgery practitioners	47%	50%

Geographic Location	Yes	No
Outstate physicians	57%	40%
Detroit Area	51%	45%

Age	Yes	No
31-40	48%	49%
41-50	53%	44%
51-60	63%	34%
> 60	58%	42%

aged 51 to 60. The percentage drops to 58 for physicians over age 60.

Willingness to treat AIDS patients

Fewer than 20 percent of physicians overall indicated reluctance to treat AIDS patients. Neither age, specialty nor geographic location breakdowns provided any significant differences in willingness to treat. The most often-cited reasons for reluctance to treat were lack of effective treatment, indicated by 22 percent of surgery specialists, and lack of confidence with knowledge of AIDS medicine, cited by 18 percent of non-surgery practitioners.

Blood/body fluid precautions

There was very little difference between surgery specialists (60 percent) and non-surgery practitioners (59 percent) in their reported adherence to proper blood/body fluid precautions. Differences in geographic location were wider — 64 percent of southeastern Michigan physicians reported always taking proper precautions compared to 58 percent of outstate physicians.

The widest variance existed in the age categories. Sixty-

Do you always take proper blood/body fluid precautions?

Specialty	Yes	No
Surgeons	60%	32%
Non-surgery practitioners	59%	38%

Geographic Location	Yes	No
Outstate physicians	58%	38%
Detroit Area	64%	35%

Age	Yes	No
31-40	64%	34%
41-50	64%	33%
51-60	54%	46%
> 60	67%	30%

seven percent of physicians aged 60 and over reported always taking proper precautions compared to 54 percent of physicians aged 51 to 60, and 64 percent of physicians aged 31 to 50.

HIV testing

A somewhat larger majority of surgeons (61 percent) than of non-surgery practitioners (54 percent) believe they should be allowed to order HIV antibody tests for their patients without informed consent. Fifty-eight percent of southeastern Michigan physicians concur with this, as do 57 percent of outstate physicians.

Differences among physician age groups is wide, but somewhat mixed: 48 percent of physicians aged 31 to 40 believe they should be allowed to test without informed consent, but this jumps to 69 percent of physicians aged 41 to 50, drops to 63 percent of physicians aged 51 to 60 and drops again to 55 percent among physicians age 60 and over.

Contact tracing

An overwhelming majority of physicians in all demographic breakdowns believes that public health authorities should be actively conducting contact tracing and notification programs for HIV infection.

Ninety-one percent of surgeons and 86 percent of non-surgery practitioners believe this should be done. Similarly, 85 percent of southeastern Michigan physicians and 90 percent of outstate physicians hold this view.

A breakdown by age reveals few differences: 82 percent of physicians aged 31 to 40, 89 percent aged 41 to 50, 93 percent aged 51 to 60, and 91 percent age 60 and over support contact tracing and notification programs.

Drug abuse and AIDS

Just over half of physicians in all demographic catego-

SPECIAL REPORT

Should physicians be able to order HIV antibody tests for patients without informed consent?

Specialty	Yes	No
Surgeons	61%	39%
Non-surgery practitioners	54%	43%

Geographic Location	Yes	No
Outstate physicians	59%	38%
Detroit Area	58%	40%

Age	Yes	No
31-40	48%	49%
41-50	69%	27%
51-60	63%	37%
> 60	55%	45%

ries favor expanding funding for treatment of drug addiction, since IV drug abuse often leads to AIDS. Fifty-eight percent of surgeons favor such funding, as do 66 percent of non-surgery practitioners. Sixty-four percent of southeastern Michigan physicians support funding for treating drug addiction, as do 59 percent of outstate physicians. Sixty-one percent of physicians aged 31 to 60 support this funding, increasing to 67 percent of physicians age 60 and over.

A smaller percentage of physicians favor providing drug addicts with sterile equipment. Forty percent of surgeons, contrasted with 45 percent of non-surgery practitioners, is supportive of this. Detroit-area physicians are somewhat more supportive (44 percent) than are outstate physicians (39 percent). Physicians aged 31 to 40 and those over 60 are more supportive, (45 percent) than are physicians aged 41 to 60 (39 percent).

Agreement with AMA AIDS policy

The AMA's AIDS policy statement recommends limiting AIDS testing to four categories of individuals: blood/organ/tissue donors; immigrants to the US; inmates to federal and state prisons; and military personnel. Agreement with this policy among Michigan physicians is somewhat mixed.

About 80 percent of nonsurgery practitioners agree with the AMA's policy of testing the first three groups, but this agreement drops to 68 percent for testing military personnel. Eighty-four percent of surgeons agree with testing blood/organ/tissue donors, while 75 percent agree with testing federal prison inmates, 71 percent with immigrants and 61 percent with military personnel.

Southeastern Michigan physicians have similarly mixed views. Eighty-four percent agree with testing tissue donors,

Should health authorities be actively conducting contact tracing and notification programs for HIV infection?

Specialty	Yes	No
Surgeons	91%	7%
Non-surgery practitioners	86%	8%

Geographic Location	Yes	No
Outstate physicians	90%	6%
Detroit Area	85%	9%

Age	Yes	No
31-40	82%	13%
41-50	89%	9%
51-60	93%	4%
> 60	91%	—

71 percent with immigrants, 78 percent with federal prison inmates and 67 percent with military personnel.

Eighty-two percent of outstate physicians agree with testing tissue donors, 71 percent with immigrants, 74 percent with federal prison inmates, and 62 percent with military personnel.

About 85 percent of physicians in all age categories agree with testing tissue donors, except for those aged 51 to 60, whose agreement is only 76 percent. Agreement with testing US immigrants is very mixed by age categories: 72 percent of physicians aged 31 to 40, 69 percent of those aged 41-50, 64 percent of physicians aged 51 to 60 and 85 percent of those over age 60.

How well informed are physicians?

A great majority of physicians across all demographic categories believe they are reasonably well informed with the scientific literature on AIDS.

Eighty-three percent of surgeons feel they are current with the scientific literature, contrasted with 78 percent of non-surgery practitioners. Slightly more Detroit-area physicians (80 percent) feel they are current with the literature than do outstate physicians (77 percent). A slightly larger percentage (82 percent) of physicians aged 41 to 50 believes they are current with the literature compared to 79 percent of physicians aged 31 to 40, 77 percent aged 51 to 69 and 76 percent age 60 and over. □

Press conference highlights need for organ donations



MSMS President Fred W. Bryant, MD, center, is flanked by State Bar of Michigan President Donald Reisig, left, and Michigan Hospital Association President Spencer Johnson at the October 19 press conference to announce the joint "Break the Silence" campaign. The purpose of the campaign is to increase the public's awareness for the need for organ and tissue donations. Joining the presidents were representatives of the state's organ and tissue donor agencies and Secretary of State James Austin. A dozen radio, television and newspaper reporters carried the story to all corners of Michigan.



MSMS President Bryant makes the point that medical advances have greatly increased the likelihood of a successful transplant and that the biggest obstacle now is the availability of donor organs and tissues. Family members are encouraged to talk about organ donation and make their wishes known before an emergency situation arises. "Break the Silence" brochures are available through MSMS.



MHA President Spencer Johnson signs a donor card held by State Bar President Donald Reisig and MSMS President Fred Bryant, MD. Secretary of State Richard Austin, at right, said only about five percent of the state's licensed drivers attach a donor sticker to their licenses. Stickers are available at all Secretary of State offices.

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MSMS Public Affairs Leadership Conference highlights



More than 90 physicians from across the state attended the 1988 MSMS Public Affairs/Leadership Conference October 19 at the Hilton Inn, Lansing. Topics at this day-long event ranged from a light-hearted, but meaningful, discussion on "Taking Charge," to a very serious discussion on the role of MSMS in "Promoting Off-Road Vehicle Safety." Also featured were three breakout sessions. These sessions addressed medicine and the media, parliamentary procedures, and medical economic trends.



Prior to the breakout session on "Medicine and the Media," MSMS President-elect Robert E. Paxton, MD, told physicians that "Times have changed, and we have to change too. Part of the change is the pervasiveness of the public media. One of the hardest things is to get doctors involved. But this is a must!"

The MSMS 1988 Public Affairs Leadership Conference, held October 19 in Lansing, offered Michigan physicians a full day of enlightening discussions — all of which were designed to help physicians "Take Charge" of their demanding lives. Among the more popular sessions of the day was "Medicine and the Media," which featured Bruce Dan, MD, senior editor of *JAMA* and medical editor for ABC News, Chicago; and Tim Skubick, a Lansing-based TV reporter. Also popular was "Taking Charge Begins Where It Ends," a lively discussion on dealing with life's changes, given by Gordon H. Deckert, MD, professor and department head, Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center. Recaps of these two sessions begin on page 770.



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Medicine and the media

The majority of people get their health messages from the mass media. And physicians must be the ones providing that information.

"If we don't, someone else will," Bruce Dan, MD, senior editor of *JAMA* and medical editor for ABC News, Chicago, told physicians at the MSMS Public Affairs Leadership Conference in October.

Doctor Dan was hammering home the point made in his introduction by MSMS President-elect Robert E. Paxton, MD. Doctor Paxton had begun the session on "Medicine and the Media," by saying:

"The times have changed, and we have to change, too. Part of the change is the pervasiveness of the public media. One of the hardest things is to get doctors involved. But this is a *must*!"

"You can reach more people in 15 minutes on TV than in all the 15-minute visits in your office," said Doctor Dan. "If you want to get your message across, you have to use TV and the other media."

To help physicians in his audience prepare for such public appearances, Doctor Dan offered this advice:

"The media will be coming to you for two things — good information, and credibility," he said. "People will believe you if you are friendly and open."

"Your MD degree gives you in-



Doctor Dan

stant credibility. We'll teach you to be friendlier, more open, more emotional before the interviewers."

Doctor Dan told his audience they must get in mind, before any interview or appearance, the most important idea they wish to convey. They must continue to express that idea throughout the interview.

He told them to think of that idea in terms of a "SOCO," (pronounced "socko"), or "Single, Overriding Communication Objective."

"Phrase your SOCO in a coherent manner, and think it out beforehand," he emphasized. "Frame what you have to say in an attention-getting manner."

"Don't try to 'wing it,' he urged. "More physicians get in trouble trying to tell people about things they don't know." □

How to handle a confrontational interview

What if you should find yourself in that most terrifying of situations — a confrontational interview with a hard-hitting, investigative news reporter?

"Ninety-five percent of interviews won't be this way," reassured Lansing-based TV reporter Tim Skubick during his segment of the "Medicine and the Media" session at the MSMS Public Affairs Leadership Conference.

"But you have to know ways to survive if you ever are in such a situation."

Skubick told physicians in his audience that they must be honest at all times with reporters. "If you stonewall, reporters will want to come after you," he cautioned.

"You can go off-the-record," he continued. "But remember, the reporter grants off-the-record status. You have to have the reporter's agreement to it."

Reporters and physicians feel more comfortable with one another if they know each other, said Skubick. He urged physicians to develop good relationships with their local news media and not to turn down the opportunity to be interviewed.

"Many reporters are going to come to you for information, but many are looking for controversy," he continued.

He reminded physicians that the definition of news is "the

Continued on page 771

deviation from the norm." And he shared with them the dominant characteristics of the hard news reporter:

- 1.) Agressive by nature in pursuing the truth. "If you say 'no comment,' I'm going to come after you."
- 2.) Suspicious by nature. "You should demand fairness from a reporter. You should get to give



Tim Skubick

your view, but the other side should come out, too."

- 3.) Anti-authoritarian. "The last thing we do is assume things at their face value."
- 4.) Disinterested, third-party observers.
- 5.) Have big egos.
- 6.) Are liberal.
- 7.) Are well-educated.
- 8.) Want to see the system work.

The reporter controls all the cards, "and you have to know that," Skubick pointed out.

"But we need you more than you need us," he acknowledged. "If we don't have good sources, we're out on the street." □

Taking charge begins where it ends

For physicians, great change is a continuous part of life; and changing with the times is a challenge. So said Gordon H. Deckert, MD, professor and department head, Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center, at the MSMS Public Affairs/Leadership Conference in October.

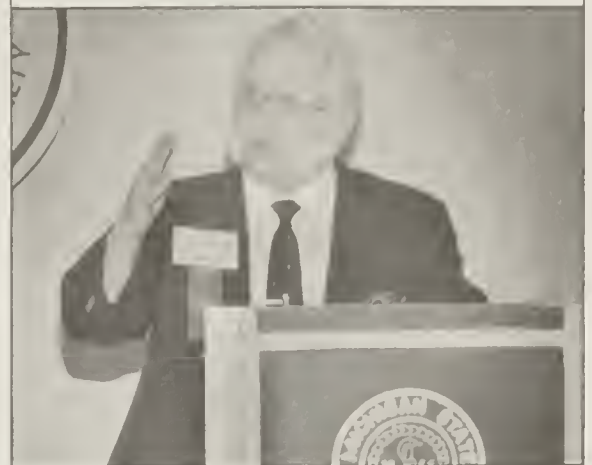
"Physicians must overcome extra obstacles, related to their needs as people, on the road to becoming a leader," said Doctor Deckert.

As a human being, a physician's view of the world is "literally" shaped by the physical structure of the brain, the environment and the characterological features of the self, explained Doctor Deckert.

As a group, physicians' views of the world tend to be colored by a strong need for power, need for economic return and "the need to know," Doctor Deckert said. "These psychological needs are strongly ingrained in most people. Changing these needs is the only way to bring about a change in one's belief system."

Physicians share with all groups of people a number of roadblocks to changing their belief systems, said Doctor Deckert. A limited view of the world is the most prevalent.

"A narrow view of the world encourages a feeling that 'My feeling is the truth' and 'My train



Doctor Deckert

of logic always leads to the truth," he said. "When these beliefs are not strong enough to support a person's worldview, people tend to guard their belief systems with defenses like denial, projection, displacement, or a host of other... responses."

For physicians, these natural difficulties in belief shifting are compounded by their "internal" character, Doctor Deckert explained. "Internals" have an overriding belief that control over their physical being and their environment is located within themselves. This characteristic belief is in direct opposition to what Doctor Deckert said is the most important quality of a leader — compromise.

"The ability to listen and the willingness to openly admit a change in position are essential qualities of a leader," said Doctor Deckert.

If a physician is to become a leader, he/she must work to change his/her view of the practice of medicine and of the physician/patient relationship, he concluded. □

IN MY OPINION/Continued

has offered risk management programs and activities since 1979, well ahead of political and public interest in risk management that flourished in the mid 1980s.

Effective "management" presupposes awareness and knowledge of what precisely it is you want to manage. In risk management, an audit of factors and conditions that give rise to claims is a typical starting point.

A basic set of risk management principles can be implemented to

prevent or minimize losses.

Ancillary staff should be involved. An assistant, receptionist or secretary can help preclude claims, plus improve patient understanding, compliance with treatment regimen and satisfaction.

Many physicians initially were skeptical about risk management.

Most now acknowledge they have modified many procedures and practices in light of a growing awareness that claims can be avoided and losses minimized.

There's another good reason to

take part in risk management programs: Participation can earn liability insurance premium credits. MPMLC, for example, can give you up to an eight percent premium credit for completing approved risk management activities, with an additional five percent credit for adhering to approved specialty society guidelines.

The bottom line is physicians and patients benefit from good risk management. □

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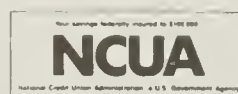
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MSMS committee keeps physicians in touch with gov't

By Chad B. Munger

Members of the Michigan State Medical Society's Committee on State Legislation and Regulations are keeping one hand on the pulse of Michigan government while keeping one hand of Michigan government on the pulse of Michigan medicine.

The Committee's 40 members represent every geographic region of Michigan and every recognized medical specialty. This broad base of experience and expertise is part of the reason the Committee has enjoyed so much success in maintaining the voice of organized medicine in Michigan government.

Mitchell A. Rinek, MD, a Lansing dermatologist, is the new chairman of the Committee on State Legislation and Regulations which was formerly headed by Frederick V. Minkow, MD, a Bloomfield Hills orthopedic surgeon.

Tracking the volumes of legislation that are produced each year by the state legislature and keeping Michigan physicians in touch with state government are the primary goals of the Committee on State Legislation and Regulations.

Identifying, explaining key bills is priority one

There is a prohibitive number of bills produced in each legislative session which may affect physicians professionally (over 150 House and Senate bills directly related to the practice of medicine were introduced in the

last two-year session). For the Committee on State Legislation and Regulations, identifying these bills and then explaining their effect on MSMS members is priority number one.

Because the volume of bills which might be considered by the Committee is so large, only those which are likely to have a significant impact on physicians or those which seem likely to be acted upon quickly by the legislature are actually considered by the Committee.

The active Committee chairman and MSMS legislative staff member Terry Vanderveen meet frequently to evaluate the content of legislation currently under consideration by the legislature and select those bills which the Committee will consider.

Current focus includes pension protection bills

Activity for the Committee this year has focused on two bills dealing with pension plan asset protection. As this year's last legislative session gets underway it appears these acts are being held hostage for other unrelated malpractice liability legislation. The Committee and MSMS members are optimistic about a last minute swing in favor of these bills.

Often times legislation which is not acted upon one year will find its way back into the legislature again in following sessions.

In 1988, issues including scope of practice, AIDS, mandatory assignment and living wills have

reappeared and have been of particular concern to the Committee. Doctor Rinek sees these as items which will continue to stimulate legislative action.

"Issues like AIDS and scope of practice are full of subtle side issues which affect a large number of different groups," he says. "Consequently, as a Committee and an organization we will continue to deal with them over a long period of time."

The Committee's momentum and intensity, started by Doctors Wil Maldonado and Minkow, former chairmen of the Committee, is something Doctor Rinek will continue in his new appointment.

"I think that medical liability and its impact on medical costs, along with mandatory Medicare assignment, are some of the most pressing issues medicine and the Michigan State Medical Society will face in the immediate future," says Doctor Rinek. "I hope that by using close legislative surveillance and maintaining a commitment to concerted action by the Committee, we will be successful in promoting the needs of the medical community in the future."

Committee has dual roles

On top of its role as legislative watchdog, the Committee on State Legislation and Regulations is responsible for keeping physicians in touch with government.

"As a Committee we can only do so much," says Doctor Rinek. "The only way MSMS will be

truly effective in promoting its views is by keeping physicians in contact with legislators. They've got to know that we are watching them and that we are interested in what they are doing."

Programs such as the Physician Legislative Network are sponsored by the Committee on State Legislation and Regulations and are aimed at intertwining the goals of organized medicine and state government. MSMS members who have not previously shown much interest in political activity and "freshman" legisla-

tors are frequently the targets of this project. Arrangements are made for physicians to spend a day at the Capitol with their representative. These days are intended to open up dialogue between physicians and politicians and to keep medicine and its needs on the minds of Michigan legislators.

According to Doctor Rinek, programs such as the Physician Legislative Network are "essential to the continued success of the Committee."

The Committee on State Leg-

islation and Regulations, described by its outgoing chairman as "very dynamic and one of the hardest-working in MSMS," is looking forward to the opportunity to make a difference in how medicine is practiced in Michigan. Says Doctor Rinek: "With the quality of the people on this Committee and the kind of commitment they have shown to making it work, I feel there is great potential for improving the quality of the medical environment in Michigan — for physicians and for patients." □

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Rep. Paul Hillegonds — A strong leader in Michigan

By Chad B. Munger

Making yourself heard in the midst of a 20-year-old political stronghold is no easy task, as Representative Paul Hillegonds (R-Holland) has discovered.

Rep. Hillegonds, the fifth-term legislator who replaced Mike Busch (R-Saginaw) as minority party leader in 1987, refuses to accept a passive Republican voice in the Michigan House.

The Republican Party has been the House minority for nearly two decades, and even Rep. Hillegonds, who is an immutable optimist, doesn't see that changing for at least four more years.

Positive leadership direction a major goal

Establishing a positive leadership direction is the first goal Rep. Hillegonds seems to have for the minority in the Michigan House.

"As a caucus, our first goal is to simply achieve an attitude change," says Rep. Hillegonds. "After being in the minority for 20 years there is the tendency to react to the other side's ideas, to be negative in our approach by simply voting no and blaming the other side when things are going wrong."

Rep. Hillegonds and Rep. Vic Krause (R-Rockford) have given new direction to a once-troubled Republican caucus. Together, the two have pushed hard to create what are known as House Republican Task Forces, where legislators, staff and caucus members come together to pound out



Representative Hillegonds

**"As a caucus, our
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change."**

party stances and objectives for House members. These well-equipped new groups are charged with studying issues that Republican House members see as most urgent to the people of Michigan. AIDS, long-term care and illegal drugs are just some of the issues on which the task forces have made recommendations. As a result, the opposing party has introduced legislation on a number of different occasions that is closely related to the recommendations presented by these task forces.

"The task forces are one of the things I'm proudest of in terms of our caucus," says Rep. Hillegonds.

The son of a Holland, Michigan minister, Rep. Hillegonds

grew up in a town in which his family was considered to be quite liberal. Rep. Hillegonds learned from his father that one should "not make assumptions too easily" and that it's important to "ask the tough questions of others and myself." These ideas are reflected in Rep. Hillegonds' involvement with the task forces, which to him have a role that goes beyond changing Republican attitudes.

Establishing a platform from which Republican House members can raise questions and encourage movement in directions where the majority might never go on their own is the second purpose Rep. Hillegonds sees for the task forces.

"What the task forces have done, I think, is to say that we can be, in effect, a shadow majority," says Rep. Hillegonds. "We can put together ideas we believe in and encourage the public and the media to look at our recommendations. In some cases, because our ideas are so sound and so well-respected, we can achieve some things by forcing the majority to look at our side. If the ideas aren't taken up, at least we have a vision about where we'd like to take this state if we could be a majority."

Education a key concern

Rep. Hillegonds was influenced early in life by the liberal moniker attached to his family, later by his education at the University of Michigan and John F. Kennedy's call to idealism. He

brought to his political career a belief in education which has remained strong despite changes in his political philosophy and his view of government's role in society.

"Of all the issues that interest us as citizens and the medical profession especially, I put how we finance education at the top of the list," says Rep. Hillegonds. "We have terrible inequities in funding per student around the state and I think that education has a lot to do with what the quality of life in Michigan will be in the years ahead."

Education, it seems, is one area that Rep. Hillegonds believes government should be responsible for regulating. "I believe that government has a role in creating opportunity, such as making sure that we fund education and level the playing field so that people can go out there and compete," he says.

Private investment needed to solve health care woes

On other issues, like health care, Rep. Hillegonds is more hesitant to rely heavily on government programs to resolve problems.

"Long-term care is a good example of something that should not be left primarily to government," he says. "I firmly believe that the only way we are going to deal with the costs of long-term care, that makes sense, is to encourage private investment and savings. If we rely solely upon the government to cover the

"Long-term care is a good example of something that should not be left primarily to government... The only way we are going to deal with the costs of long-term care is to encourage private investment and savings."

costs, we are going to bring upon ourselves a national health care system that we will all come to regret."

The direction of health care in this country is at a turning point, says Rep. Hillegonds. He sees both state and national government taking more time to address the problem of "not meeting current obligations in health care."

Meeting the costs of medical liability is a problem Rep. Hillegonds would like to see eliminated for the physicians in his district. The need for malpractice reform in Michigan seems self-evident, says Rep. Hillegonds. "High liability costs lead to overly defensive medicine and eventually to an availability problem, as young physicians become discouraged and leave the state and older physicians opt for early retirement."

Physicians need to be more politically involved

Rep. Hillegonds, who, when describing his professional experiences says, "My whole life has been in politics," would like to see

physicians become more actively involved in politics. Monetary involvement by physicians is just not enough.

"As nice as a campaign contribution is, physician information and input on the issues is more important," he says. "I would like to see physicians all over the state writing their legislators more often and getting together with them. I would especially like to see physicians getting together with those members in the House that haven't been friendly toward issues like malpractice reform or the rate of reimbursement for Medicaid. Those two issues have been very tough for physicians in the last few years."

"What I want most," says Rep. Hillegonds, "is a chance to help set the Agenda." For now, Rep. Hillegonds must be patient and content to listen to the voice of his constituency, while struggling to make the voice of the House minority heard. □

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INDICATIONS AND USAGE

Cipro[®] is indicated for the treatment of infections caused by susceptible strains of the designated micro-organisms in the conditions listed below

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Skin and Skin Structure Infections caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Proteus mirabilis*, *Proteus vulgaris*, *Providencia stuartii*, *Morganella morganii*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis*, and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae*, *Serratia marcescens*, and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Serratia marcescens*, *Proteus mirabilis*, *Providencia rettgeri*, *Morganella morganii*, *Citrobacter diversus*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus epidermidis*, and *Streptococcus faecalis*.

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni*, *Shigella flexneri*,* and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro[®] may be initiated before results of these tests are known, once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN, ADOLESCENTS, OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General: As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Quinolones may also cause anaphylactic reactions and cardiovascular collapse. Anaphylactic reactions may require epinephrine and other emergency measures.

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions: Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients: Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V₇₉ Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy—Pregnancy Category C: Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

CONVENIENT B.I.D. DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg q1
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg q1
Urinary Tract*	Mild/Moderate	250 mg q1
	Severe/Complicated	500 mg q1
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg q1

Nursing Mothers: It is not known whether ciprofloxacin is excreted in human milk, however, it is known ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those terms that are italicized are included in the package insert.

GASTROINTESTINAL (See above), painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding.

CENTRAL NERVOUS SYSTEM (See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.

SKIN/HYPERSENSITIVITY (See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyperpigmentation, erythema nodosum.

Allergic reactions ranging from urticaria to anaphylactic reactions have been reported.

SPECIAL SENSES blurred vision, disturbed vision, change in color perception, overbrightness of light, decreased visual acuity, diplopia, eye pain, tinnitus, bad taste.

MUSCULOSKELETAL joint or back pain, joint stiffness, achiness, neck or chest pain, flare-up of gout.

RENAL/UROGENITAL interstitial nephritis, renal failure, polyuria, urinary retention, urethral bleeding, vaginitis, acidosis.

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic—Elevations of ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.8%), serum bilirubin (0.3%).

Hematologic—eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal—Elevations of Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gamma-glutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, and bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro[®] (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, a Unit-Dose package of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

*Due to susceptible strains of indicated pathogens. See indicated organisms in Prescribing Information.

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Physicians to face new, complex health, life insurance rules

By Curtis J. DeRoo

Editor's note: The following article concerns new health and life insurance rules which will become effective January 1, 1989. The rules are stipulated in Section 89 of the Internal Revenue Code, a new section which has been added as part of the 1986 Tax Reform Act. The rules, as explained in the following article, are complex. Therefore, physicians are encouraged to consult with their financial/legal advisors for further explanation.

Current law provides that group health and group life insurance plans are tax deductible expenses to employers. A small amount of the life insurance benefit (that in excess of \$50,000 per year) may be taxable to some employees, but largely both health and life insurance benefits are tax-free fringe benefits to employees.

As part of the 1986 Tax Reform Act, a new Section 89 was added to the Internal Revenue Code. Section 89 sets forth various qualification standards and non-discrimination rules in order to have health plans and group life insurance plans continue as tax deductible fringe benefit programs for employers, and tax exempt benefits for employees.

Section 89 will be effective for insurance plans beginning on or after January 1, 1989. Since most fringe benefit plans operate on a calendar year, these provisions will generally affect everyone beginning January 1.

Section 89 will affect all employers. Initially, there was some hope that "small" employers (those with 20 or less employees) would be exempt, but as of the

writing of this article, no such regulation exists. In light of congressional concern over perceived abuses of health and group life insurance plans, small employers will probably not be exempt.

Section 89 is applicable to "statutory fringe benefit plans," which include health and group term life insurance plans. Most of the requirements of Section 89 will apply to those plans, but the term "statutory fringe benefit plan" also includes qualified tuition reduction plans, cafeteria plans, welfare funds (VEBA's), dependent care assistance plans, and any other fringe benefits that are available under Section 132 of the Internal Revenue Code, such as employee discounts, working condition fringe benefits, or de minimus fringe benefits.

Each plan must satisfy the qualification rules; some plans have to follow the non-discrimination rules. Each of these rules are discussed in the following paragraphs.

Qualification rules

The qualification rules apply to *all* statutory employee fringe benefit plans. As such, they apply not only to the health and group term life insurance plans, but to

any other fringe benefit plan that the employer offers its employees. The rules are relatively simple and are stated as follows:

1.) The plan must be in writing.

2.) The employees' rights under the plan must be legally enforceable.

3.) The employees must be provided with reasonable notification of the benefits available under the plan.

4.) The plan must be maintained for the exclusive benefit of employees.

5.) The plan must be established with the intention of being maintained indefinitely.

The above requirements can be met by simply embodying any fringe benefit program into a written document, and by giving copies of the document to the employees.

If the above requirements are not met, severe penalties apply. First of all, the cost of providing the coverage will not be deductible to the employer. Secondly, the employees must include in their gross income the value of the *benefit* when it is received, to the extent that it is attributable to an employer contribution. It is important to note that the em-

Continued on next page

Mr. DeRoo is an attorney with Kerr, Russell and Weber, Detroit.

INSURANCE/Continued

ployee is not taxed on the value of the coverage (i.e. the health insurance plan), but is instead taxed on the benefit that is received (presumably the value of the health insurance services that are given).

Due to the harshness of the penalties, it is imperative that every plan satisfy the qualification standards, which are not terribly onerous.

Non-discrimination rules

The non-discrimination rules apply to all health and group term life insurance plans. At the option of the employer, the employer may also apply these non-discrimination rules to other statutory fringe benefit plans, but that is not required. The non-discrimination tests are rather technical, and are applied in the alternative. Each plan must cover 80 percent of employees, or must satisfy certain eligibility/benefits rules. These will be described in more detail in later paragraphs.

The penalty for failing to satisfy the non-discrimination rules is that the excess coverage is taxable income, and is reported on the W-2 of the employee, in the same way that life insurance coverage in excess of \$50,000 is taxable income to that employee. However, if the employer does not properly report the excess benefit on the W-2 all of the benefit is considered excess and the entire benefit is treated as taxable income. These penalties only

apply to highly-compensated employees.

Non-discrimination test

Before an intelligent discussion can be made of the non-discrimination test, a number of definitions must be established. "Highly compensated employees" include: employees who own five percent of the business; employees who receive compensation in excess of \$75,000 per year; employees who receive compensation in excess of \$50,000 per year and are among the top 20 percent of compensated employees; and employees who are officers of the employer and receive compensation that is in excess of \$45,000 per year.

For the purposes of Section 89, the term "plan" includes each option or different benefit level that is offered. For example, a plan that offers both family and individual health insurance coverage is two separate plans; one that offers individual coverage and one that offers family coverage for the non-employee family members. In a similar vein, plans that are similar except for different deductible amounts would also be different plans.

"Comparable plans" are any group of plans of the same type (two different health plans, for example), as long as the small benefit available to an employee in one plan is equal to 95 percent of the largest benefit that is available in the other plan.

The term "employee" includes not only common law employees,

but also partners and individual proprietors.

The term "employer" includes not only the traditional employer, but also a sole proprietor or a partnership. Some employees may be excluded from testing.

"Excluded employees" include those who have not completed six months of service for core benefit health plans, or one year of service for all other plans, including life insurance. Excluded employees also include those employees who normally work six months or less during any year, employees under the age of 21, employees who are subject to collective bargaining agreements, and non-resident aliens. However, if any employee who is otherwise excludable is eligible to participate in a plan, all similarly situated employees will be included for testing purposes.

The 80 percent coverage test is applied by first dividing all of the employees into two groups. The highly-compensated employees are lumped together in one group; all other employees (non-highly compensated) are lumped into a separate group.

If at least 80 percent of the employees who are not highly compensated are covered during the plan year, and there is no term in the plan relating to eligibility that discriminates in favor of the highly compensated employees, the plan will pass the 80 percent coverage test and will not have to be further tested. Plans

Continued on page 784

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INSURANCE/Continued

that are comparable may be aggregated; for purposes of testing health plans, employers can test employees and dependents as separate plans.

If the 80 percent coverage test is not satisfied, then the eligibility and benefits test must be satisfied.

The eligibility test has three requirements: (1) Ninety percent of the non-highly compensated employees must be eligible to participate in the plan (or another

plan of the same type), and have available to them an employer provided benefit that is at least 50 percent of the largest employer provided benefit available to the highly compensated employee; (2) Fifty percent of the employees eligible to participate in the plan or plans of the same type and "comparable," must be non-highly compensated employees; and (3) No discrimination can exist in favor of the highly compensated employees.

After the eligibility test is passed, the benefits test must also

be passed. The average employer provided benefit received by the non-highly compensated employee in all plans of the same type must be equal to or exceed 75 percent of the average employer provided benefit received by highly compensated employees in all plans of the same type. □

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All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. Please consult brief summary of Prescribing Information on the following page.

BRIEF SUMMARY (FOR FULL PRESCRIBING
INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS

In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS

Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS

Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION

Therapy should be initiated with application of one Transderm-Nitro 5 mg 24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 mg 24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg 24 hr system. If a single Transderm-Nitro 5 mg 24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg 24 hr systems or one Transderm-Nitro 10 mg 24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg 24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS

A patient leaflet is supplied with the systems.

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C I B A

References:

1. Martinez C. Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H. Transdermal nitroglycerin antianginal comparative trial involving oral nitrates. The Transderm-Nitro A C T I O N Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium, San Francisco, October 1987.

Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: LeRoy Alcox, Jr., MD

Action, Date Taken: Denied, September 21, 1988.

Reason: Reinstatement.

Name: James E. Ives, MD

Action, Date Taken: Probation—one year; Reprimand—fine \$500. Earn 35 Category I hours in addition to the 150 CME mandated for license renewal. September 15, 1988

Reason: Failed to demonstrate compliance with CME required for relicensure.

Name: Luzviminda S. Jardenil-Lira, MD

Action, Date Taken: Probation—two years; Reprimand—fine \$500. Earn 100 Category I hours in addition to the 150 CME mandated for license renewal. September 15, 1988

Reason: Failed to demonstrate compliance with CME required for relicensure.

Name: Natalio Kogan, MD

Action, Date Taken: Probation—two years; Reprimand—fine \$500. Earn 100 Category I hours in addition to the 150 CME mandated for license renewal. September 15, 1988

Reason: Failed to demonstrate compliance with CME required for relicensure.

Name: Earl Stanley Perrigo, MD

Action, Date Taken: Reprimand & Probation. September 27, 1988 to July 10, 1990. September 27, 1988.

Reason: Drug related.

Name: Donald G. Weathers, MD

Action, Date Taken: Probation—two years; Reprimand—fine \$500. Earn 62 Category I hours in addition to the 150 CME mandated for license renewal. September 16, 1988

Reason: Failed to demonstrate compliance with CME required for relicensure.

It's up to physicians to keep their licenses current

By Thomas J. DeKornfeld, MD

The license to practice medicine is, for most of us, second in importance only to our marriage license. Yet sometimes we treat this precious privilege in a surprisingly cavalier fashion.

Every few weeks we get anguished calls from a practitioner who suddenly discovers that his/her license has expired and lapsed and that he/she has been practicing medicine without a license for some months or even

Doctor DeKornfeld is administrator of the Board.

for more than a year. This sudden discovery usually occurs when the third party payers advise the ex-practitioner that he/she owes many thousands of dollars to the third party payers for reimbursements which were made to him/her as unlicensed practitioners.

When this happens, there is usually nothing we can do about it. The responsibility to keep a license current rests entirely and totally with the physician. We send renewal applications in a timely fashion to the last and best

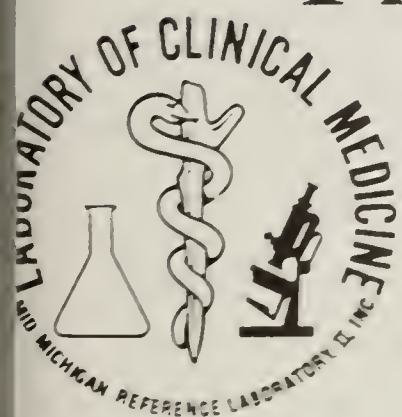
address we have. Each year we get between 200 and 300 renewal applications back from the post office marked "undeliverable."

We check these returned envelopes, and do everything we can to determine the correct address and send another renewal application. We also work with the MSMS Membership Department to try to track people down. Incidentally, not advising the Board about an address change within 30 days is a violation of

Continued on next page

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BOARD OF MEDICINE/ Continued

the Public Health Code. That, in and of itself, could lead to a sanction.

My plea to all of you is to please look at your license, and check two things:

1. Is the address that appears on the license the correct one?
2. When will the license expire?

If you work in a group or are employed by an HMO, hospital or other organization, make sure that the business manager has a renewal date file for all physicians in the group or organization and that the appropriate address changes are made in a timely fashion.

If the license was lapsed for less than three years, it can be reinstated relatively simply, but it may still take an appreciable amount of time. An application must be made, the fee must be paid and evidence must be submitted that you have met the CME requirements for the lapsed period. Additionally, if in the interim the physician has practiced in another state, we must have verification from the other state or states, that the license is in good standing. If, however, the license had been lapsed for more than three years, a reinstatement application must be handled like a brand-new application and the physician will have to take FLEX all over again and meet all other requirements for a new license.

We also have problems with

people who are, or should be, holding a limited educational license. Every year we discover that there are some who have never applied for a limited educational license until the day that they are supposed to start their training. Usually the hospital discovers this and does not allow the person to start the training. But we also have encountered situations where the hospital did not discover until the end of the first year, and it was renewal time, that Doctor X never had a limited educational license. This also is a serious matter since, technically, the time spent without a license, other than being a felony, cannot be certified as a legitimate training period by the training institution. This, in turn, may mean that this person may not be eligible for the specialty Boards at the time they expected to take them. In this instance there again is nothing we can do and there is no way we can provide a retroactive license.

Once again the responsibility for having a valid educational limited license rests with the physician. The training institution should monitor this matter, and most of them do. Some unfortunately do not or do it only very haphazardly. Be that as it may, the ultimate responsibility is with the physician. □

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

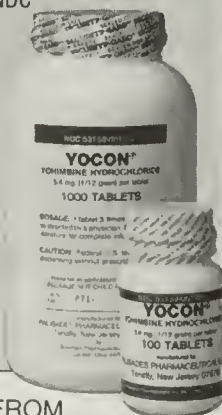
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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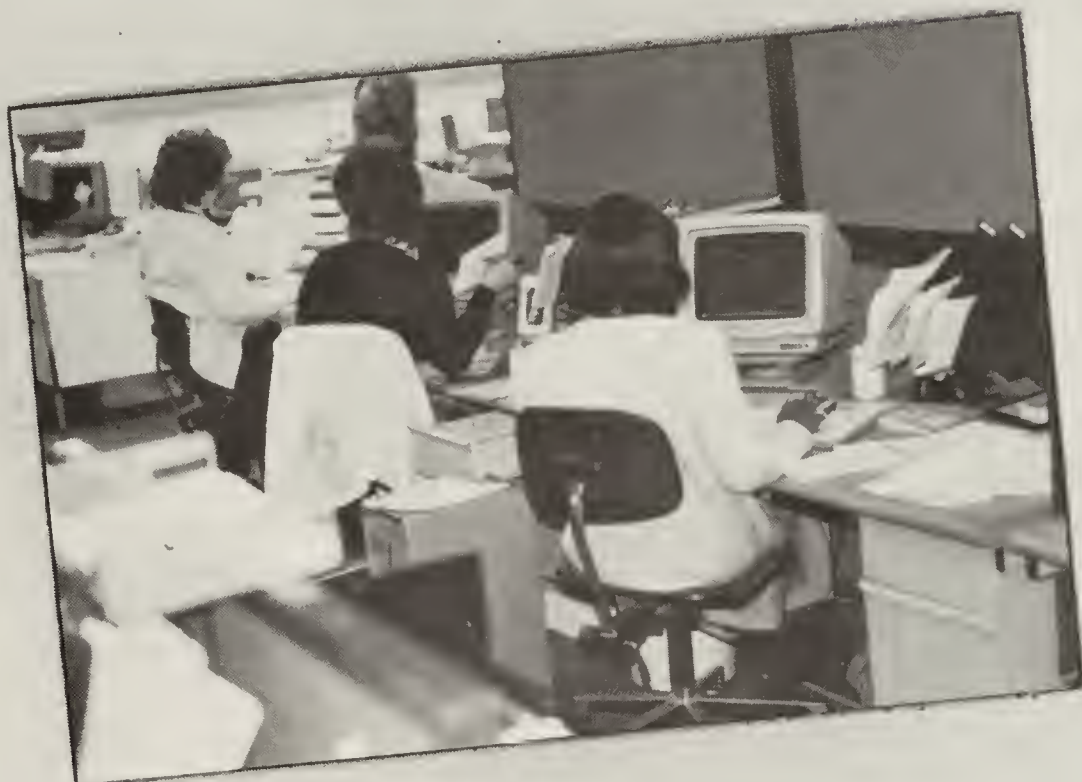
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After 10 years of service at the Ingham County Health Department, J. Maxwell Cook, MD, is retiring as medical director. Dean Sienko, MD, has been appointed to succeed him. Doctor Sienko spent three years with the Centers for Disease Control as an EIS Officer and Preventive Medicine Resident. He is currently employed as a medical epidemiologist in the Center for Health Promotion, Michigan Department.

Lawrence Koltonow, MD, Medical Director of Adult Services, Havenwyck Hospital, Auburn Hills, Mich., recently spoke at the Fourth International Symposium on High Technology in Banking which was held in West Berlin. Doctor Koltonow's talk was entitled "You Are Never Comfortable in a Room You Cannot Get Out Of."

George D. Zuidema, MD, vice provost for medical affairs at the University of Michigan, has been named to the Council on Graduate Medical Education, an advisory panel within the US Department of Health and Human Services. His appointment was announced by Rep. Carl Pursell, (R-Plymouth), who nominated Doctor Zuidema for the advisory post. Doctor Zuidema's four-year, non-salaried term began Oct. 1.

Retired Pontiac otolaryngologist is honored for his efforts to establish hearing institute

Retired Pontiac otolaryngologist Bruce Proctor, MD, received the Founders Award October 2 from the Kresge Hearing Research Institute of Ann Arbor.

Doctor Proctor was cited "for his wisdom in recognizing the basic need for research in hearing and deafness and for inspiring support for the world's first and now leading institute for studies of hearing and the mechanisms of deafness."

The Kresge Institute, founded in 1963, now receives the highest percentage of any single institution granted US government funds devoted to hearing and deafness research. Doctor Proctor recalls persuading Stanley Kresge, then president of the Kresge Foundation, of the need for the institute.

"I told him such an institute would be good in Ann Arbor, where basic science resources are located to back it up," says Doctor Proctor. "He gave the money."

Though retired from active practice, Doctor Proctor has just finished a 300-page textbook entitled *Surgical Anatomy of the Ear and Temporal Bone*. It will be published in January by the Thieme Company of New York City.

Doctor Proctor now is hard at work raising funds to develop a neurological institute in Ann Arbor. A 25-member advisory

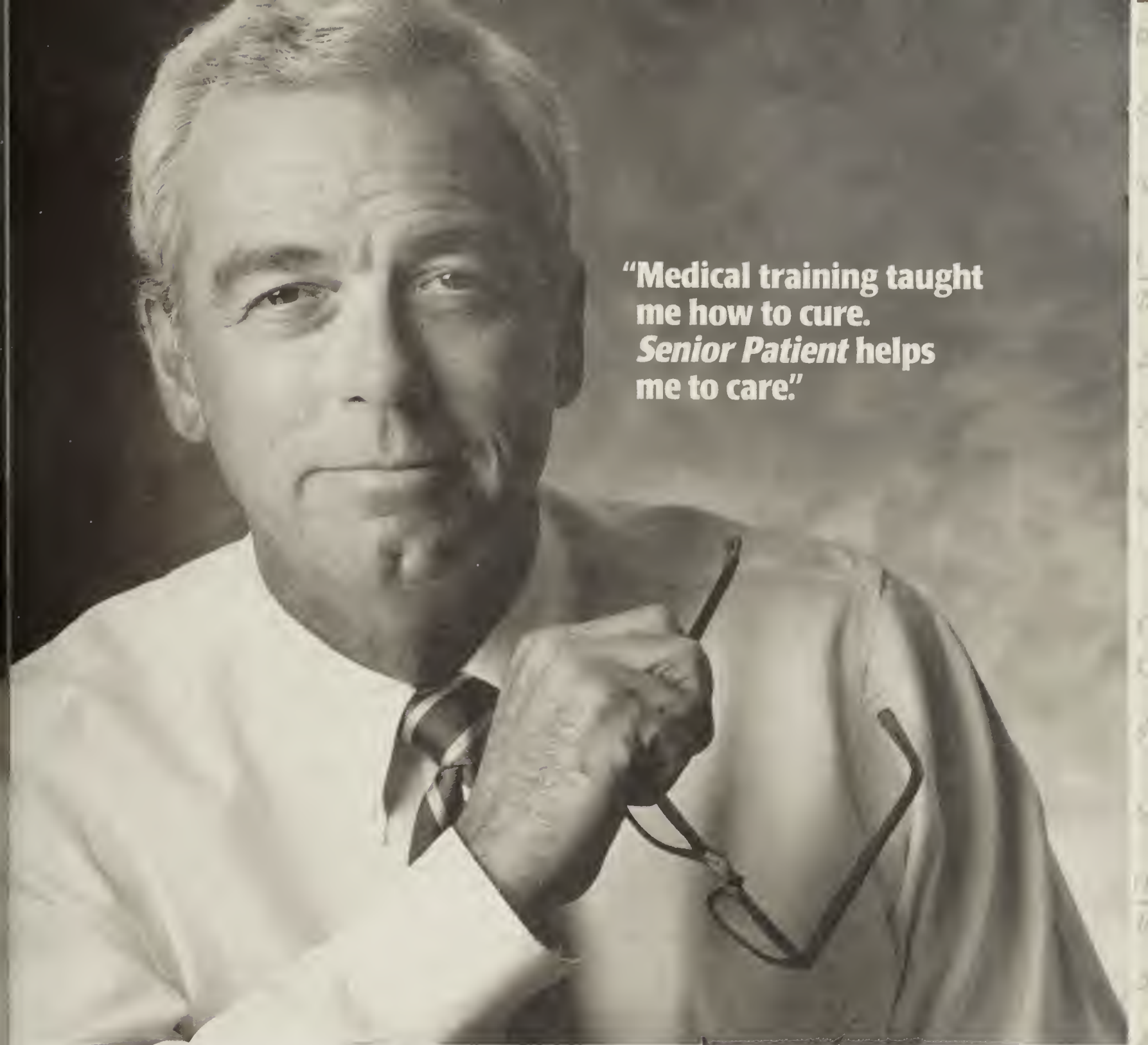


Bruce Proctor, MD, left, receives the "Founders Award" from Charles J. Krause, MD, chairman, Department of Otolaryngology, University of Michigan Medical Center. The award was presented at the 25th anniversary celebration of the Kresge Hearing Research Institute Oct. 2.

committee of prominent people is highly interested in establishing the institute, says Doctor Proctor. "I think it will be a success."

"There is no such thing in this country," he continues. "It will be good to have one here."

When recognized for his dedication to establishing the Ann Arbor institutes, particularly now that he's retired, Doctor Proctor says, "It's just that some people like to spend their time playing golf, you know. I prefer to spend mine doing this sort of thing."



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LETTERS/Continued

Thus, a curriculum that emphasizes primary care and family practice is an important factor in encouraging medical students to specialize in those areas.

The Upper Peninsula program is very small and consequently has a small impact on the staggering problem of physician maldistribution in Michigan and the US. However, the program does provide a model for educating rural primary care physicians that has proven to be successful.

Significant improvement in the numbers of medical students choosing primary care specialties cannot realistically be expected until primary care clinical training programs are developed by the majority of medical schools in this country.

The second recommendation suggests that Michigan develop a state loan forgiveness program for physicians who practice in shortage areas. On a very limited scale, the UP program is doing that by awarding sizeable scholarships to senior medical students

who intend to return to the UP to practice. The scholarships are considered repaid in full after the graduate has completed two years of practice in the Upper Peninsula.

The establishment of an Area Health Education Center (AHEC) is also recommended. The College of Human Medicine established an AHEC in Lower Michigan several years ago, centering its administrative activities at the Saginaw campus. The

Continued on page 804

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CONTINUING EDUCATION Neurology and Neuro-
surgery Research Fellowship Training, National Institutes
of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial
Fellowship, National Masonic Medical Research Foundation;
Albert Schweitzer Fellowship, International Albert Schweitzer
Foundation; Harvard Medical School Cabot Prize for Best
Senior Thesis; recently published article, "Who Shall Live
and Who Shall Die" in Newsweek Magazine.



“The work I’m doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn’t ask for a smoother transition. And that’s true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

“Some of the projects the Army is undertaking are on the cutting edge of research. For example, I’m currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

“The quality of medicine and the caliber of people I’ve been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I’m giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General.”

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Summary.

Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

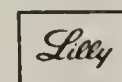
- Gastrointestinal (mostly diarrhea) 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthritis, and frequently, fever) 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
 - As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
 - Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
 - Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
- Abnormalities in laboratory results of uncertain etiology:**
- Slight elevations in hepatic enzymes.
 - Transient fluctuations in leukocyte count (especially in infants and children).
 - Abnormal urinalysis, elevations in BUN or serum creatinine.
 - Positive direct Coombs' test.
 - False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

(061088L)

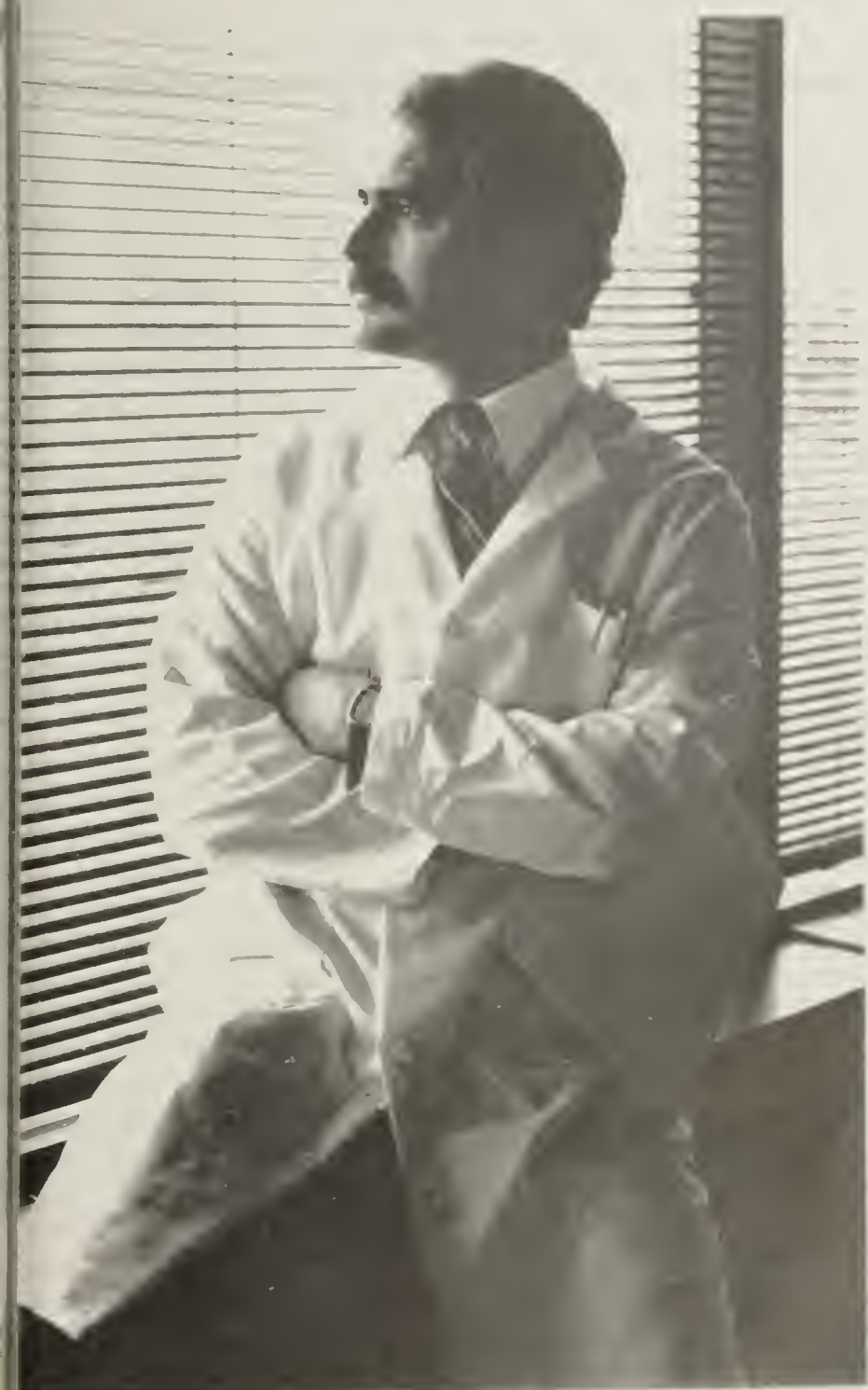
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New law preserves physicians' right to distribute drug samples

By Gerald J. Mossinghoff, president
Pharmaceutical Manufacturers Assoc.

Physicians should know that their right to use and distribute drug samples to patients is in no way affected by the new Prescription Drug Marketing Act, which was signed into law by President Reagan in April.

The main thrust of the Prescription Drug Marketing Act is to establish new requirements affecting the distribution and marketing of prescription drugs. Of specific interest to physicians are the provisions that ban the sale, trade or purchase of drug samples



THEODORE W. KILAR, M.D.

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"The main thrust of the (law)... is to establish new requirements affecting the distribution and marketing of prescription drugs."

and require manufacturers which distribute pharmaceutical samples to follow certain storage, handling and accounting procedures.

Criminal penalties were put into effect on July 22, 1988, for anyone who sells, trades or purchases drug samples. The penalties can be as much as ten years in prison and up to \$250,000.

The physician needs to keep in mind a few points about this new law:

1. The law does not prevent physicians from receiving or dispensing drug samples.

2. In order to receive samples, physicians are required to sign a written request form verifying the identity of the drug and the quantity requested. This part of the law became effective October 20, 1988. This written request form is required by some states and is already commonly used by manufacturers.

3. Although the law does not require physicians to maintain records, manufacturers may ask physicians for their help in assuring that they did receive the samples requested. While the new law does not mandate physicians to cooperate with this verification procedure, the law does encourage manufacturers to im-

plement such a system.

The Pharmaceutical Manufacturers Association and the American Medical Association convinced Congress that the initial proposals to ban samples would hamper efforts to provide quality medical care.

Samples allow the physician to evaluate a specific drug to ensure the patient tolerates it and to determine if the drug has the desired effect. Samples also permit the physician to begin therapy immediately, which can be very important in some cases, especially in rural areas.

As a result, the legislation that was passed does not threaten the practice of sampling, but does help safeguard the integrity of prescription drugs distributed in this manner. In fact, many of the procedural requirements imposed on manufacturers have long been established policies for PMA member companies.

Physicians and patients value drug samples, according to surveys, and believe the practice of sampling should continue. PMA and its member companies also believe in the value of sampling and we will work to implement this new law smoothly so that samples can continue to play a useful role in patient care. □

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LETTER/Continued

AHEC coordinates rural health care activities in rural areas in the northern portion of the lower peninsula. Although not officially deemed an AHEC, the Upper Peninsula Health Education Corporation so closely resembles one that the government does not consider it necessary to create an AHEC for the Upper Peninsula.

Cooperation is the key

Several of the recommenda-

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tions made in your article are already being addressed by the College of Human Medicine at Michigan State University. However, the problems faced by rural Michigan physicians are not easily resolved and the cooperation of medical schools and physician groups in the state will be required if a real impact is to be made on the maldistribution problem.

Michigan State University College of Human Medicine and the Upper Peninsula Health Education Corporation appreciate the interest and the concern of *Michigan Medicine* in highlighting the problems of rural medicine. We realize that our program is not widely known and welcome your further interest in us and in our future plans.

Tom M. Johnson, MD
Associate Dean
Michigan State University
College of Human Medicine

John M. Hicker, MD
Asst. Director of
Medical Education
Upper Peninsula Campus

Daniel S. Mazzuchi, MD
Assistant Dean
Upper Peninsula Campus

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Coordinator of Research
Upper Peninsula Campus

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

January

7, Today's Drug-Seeking Society: The Risks, The Reckoning, The Rehabilitation. Location: William Beaumont Hospital. Sponsor: William Beaumont Hospital, Department of Psychiatry. Contact: William Beaumont Hospital, Department of Psychiatry, 3601 W. Thirteen Mile Rd., Royal Oak, MI 48072 (313) 280-8449. Approved for: 6 hours Category I Credit.

13, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category I Credit.

14-15, Advanced Cardiac Life Support Provider Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 16 hours Category I Credit.

29-2/3, The Thirteenth Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbour Springs. Sponsor: University of Michigan Medical School, Department of Family Practice with the Michigan Academy of Family Physicians, and Department of Postgraduate Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 20 hours Category I Credit.

February

10, Basic Life Support for Health Profes-

sionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 5 hours Category I Credit.

11, Advanced Cardiac Life Support Recertification Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 7 hours Category I Credit.

10-12, Advanced Cardiac Life Support Instructor Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 21 hours Category I Credit.

13-17, Eighth Postgraduate Course on Myocardial Infarction and Angina Pectoris. Location: Convention Center, Davos, Switzerland. Sponsor: University of Michigan Medical School, Hanover Medical School, Hanover, West Germany. Contact: Karen McCalla, Marketing Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 28 hours Category I Credit.

27-3/3, Microvascular Workshop for Otolaryngologists and Head and Neck Reconstructive Surgeons. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor:

University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery, and American Academy of Facial Plastic and Reconstructive Surgery. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 41 hours Category I Credit.

March

2-4, Advances in the Management of Infectious Diseases. Location: South Seas Plantation, Captiva Island, Florida. Sponsor: University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 12 hours Category I Credit.

9-14, 12th Annual Ophthalmology: Basic and Clinical Review Course. Location: Wayne State University School of Medicine, Detroit. Sponsor: Kresge Eye Institute of Wayne State University School of Medicine. Contact: Division of Continuing Medical Education, Wayne State University School of Medicine, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313) 577-1180. Approved for: 42 hours Category I Credit.

14-18, Family Practice-1989 Thirteenth Annual Spring Review Course. Location: Towsley Center, University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Family Practice and the Michigan Academy of Family Physicians. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 34 hours Category I Credit.

25-4/1, Facial Cutaneous Surgery: Mohs, Reconstructive, Cosmetic. Location: Copper Mountain Resort, Copper Mountain, Colorado. Sponsor: University of Michigan Medical School, Department of Otolaryngology, Head and Neck Surgery. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 30 hours Category I Credit.

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MEETINGS

MSMS MEETINGS

January

18, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

March

2, First Annual MSMS Young Physicians Section Meeting, Lansing Sheraton Inn, contact: Linda Munson, MSMS Young Physicians Section, (517) 337-1351.

8, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

22-23, Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyond The Horizon," Hyatt Regency Dearborn, Contact: Sherry L. Fent, (517) 337-1351.

MICHIGAN SPECIALTY SOCIETY MEETINGS

January

19, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

February

16, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

March

16, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

April

20, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

May

4-5, Michigan Chapter, American College of Surgeons Collier Competition and Annual Meeting, Sheraton University Inn, Ann Arbor, contact: Viola M. Heins, P.O. Box 950, East Lansing 48826-0950, (517) 337-1351.

NATIONAL SPECIALTY SOCIETY MEETINGS

February

5-8, American Society for Parenteral and Enteral Nutrition: 13th Clinical Congress, Fontainebleau Hilton, Miami Beach, contact: A.S.P.E.N., 8605 Cameron Street, -500, Silver Spring, MD 20910 (301) 587-6315.

9-14, American Academy of Orthopaedic Surgeons Annual Scientific Meeting, Las Vegas, NY, contact: American Academy of Orthopaedic Surgeons, 222 S. Prospect, Park Ridge, IL 60068 (312) 823-7168.

24-3/1, American Academy of Allergy and Immunology Annual Meeting, Convention Center, San Antonio, TX, contact: American Academy of Allergy and Immunology, 611 E. Wells St., Milwaukee, WI 53202 (414) 272-6071.

March

2-5, American College of Nuclear Physicians Annual Scientific Meeting, Sheraton Bal Harbour, Bal Harbour, FL, contact: American College of Nuclear Physicians, 1101 Connecticut Avenue, N.W., Suite 700, Washington, DC 20036 (202) 857-1135.

19-23, American College of Cardiology Annual Scientific Meeting, Hilton Inn, Anaheim, CA, contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 (301) 897-5400.

19-24, American Association of Pathologists Annual Meeting, New Orleans, LA, contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814 (301) 530-7130.

April

2-6, American Association of Neurological Surgeons Annual Meeting, Washington, DC, contact: American Association of Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312) 692-9500.

4-6, American Laryngological, Rhinological and Otological Society Annual Scientific Meeting, Fairmont Hotel, San Francisco, CA, contact: The Triological Society, P.O. Box 155, East Greenvew, PA 18041 (215) 679-7180.

12-16, American College of Preventive Medicine Annual Scientific Meeting, Westin Hotel, Atlanta, GA, contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202) 789-0003.

13-16, American College of Physicians Annual Meeting, San Francisco, CA, contact: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104 (215) 243-1200.

13-19, American Academy of Neurology Annual Scientific Meeting, Hynes Convention Center, Chicago, IL, contact: American Academy of Neurology,

2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612) 623-8115.

29-5/5, American Occupational Medical Association Annual Scientific Meeting, Sheraton Boston, Boston, MA, contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312) 228-6850.

May

6-12, American Psychiatric Association Scientific Meeting, San Francisco, CA, contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005 (202) 682-6000.

7-10, American Association of Plastic

Surgeons Annual Meeting, Camelback Inn, Scottsdale, AZ, contact: American Association of Plastic Surgeons, The John Hopkins Hospital, 601 N. Wolfe Street, Harvey 811, Baltimore, MD 21205 (301) 669-7601.

7-11, American Urological Association Annual Meeting, Infomart/Loews Anatole Hotel, Dallas, TX, contact: American Urological Association, 1120 N. Charles Street, Baltimore, MD 21201 (301) 727-1100.

8-10, American Association for Thoracic Surgery Annual Meeting, Sheraton/Hynes, Boston, MA, contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

13-17, American Society for Gastrointestinal Endoscopy Annual Scientific Meeting, Sheraton Hotel, Washington, DC, contact: American Society for Gastrointestinal Endoscopy, Thirteen Elm Street, Manchester, MA 01944 (617) 927-8330.

13-19, American Gastroenterological Association Annual Scientific Meeting, Sheraton Washington and Shoreham Hotels, Washington, DC, contact: American Gastroenterological Association, 6900 Grove Road, Thorofare, NJ 08086 (609) 848-1000.

14-17, American Thoracic Society Annual Scientific Meeting, Convention Center, Cincinnati, OH, contact: American Thoracic Society, 1740 Broadway, New York, NY 10019 (212) 315-8778.

22-25, American College of Obstetricians and Gynecologists Annual Meeting, Convention Center, Atlanta, GA, contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024 (202) 638-5577.

28-31, American Pediatric Surgical Association Annual Meeting, Hyatt Regency Inner Harbor, Baltimore, MD, contact: American Pediatric Surgical Association, Johns Hopkins Hospital, Baltimore, MD 20105 (301) 955-6256.

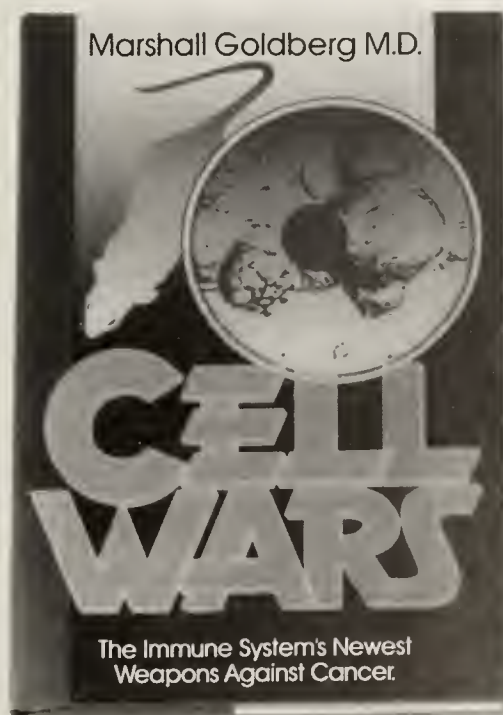
June

11-15, American Society of Colon and Rectal Surgeons Annual Meeting, Sheraton Centre, Toronto, Ontario, Canada, contact: American Society of Colon and Rectal Surgeons, 615 Griswold, Suite 1717, Detroit, MI 48226 (313) 961-7880.

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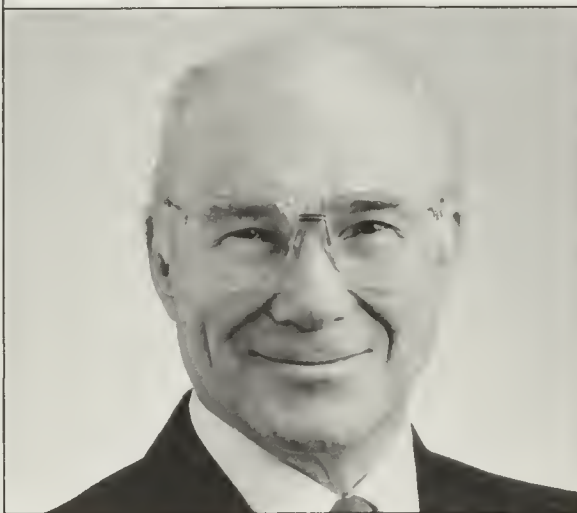
By Fred W. Bryant, MD

Winter is the nadir, the absolute zero of nature's physiologic activity. Life's fires ebb, burn low, and flicker dimly. There is no scent of flowers or hum of insects. Bony trees are gaunt skeletons of their summer selves. Pond surfaces, robbed of their sparkling wave movements are rendered expressionless by congealed, rigid layers of ice. Everywhere there is an empty panorama, a landscape of gray grass compressed by sullen slate skies. All and all, it is a cold, bleak and inert environment, a most unlikely setting for warmth and inspiration.

Au contraire! By coincidence, or perhaps due to inaccurate projections of ancient calendars linked imperfectly to lunar and solar gyrations, the cold months capture and contain the bulk of our religious and sentimental commemorative days.

On Thanksgiving Day we pause to express gratitude for past favors, large and small. The story of the inconspicuous birth of an infant under most modest circumstances, in an out-of-the-way stable in a crowded town with standing-room only, has perennial appeal and causes widespread rejoicing. The arrival of the new year is a time of appraisal, reaffirmation and enthusiasm. The Jewish equivalent, Rosh Hashanah, literally means "the head of the year." And, Yom Kippur is the Jewish day of atonement.

Actually, there are many parallels and common denominators



Doctor Bryant

in the religious denominations of the world. There are structural similarities to temples, the domes of Mosques and Synagogues, and church spires compared to minarets. We share sounds — the Muzzein's summons to prayer, the cantors' chant, the choirs' chords. There are visual likenesses, too — the Star of Bethlehem and the Star of David, and candles in all arrangements from a solitary taper to flaming candlebras, or a whole festival of lights. The texts — the Talmud, Bible, and the Koran. Various postures are common to all — hands cupped in prayer, knees genuflected in supplication, eyes closed in concentration or raised heavenward in reverence. The multiple hand and arm positions of Buddha idols express prayer and human attitudes.

And now the end of the year approaches. Hark! The Herald Angels Sing! Noel! Adeste Fideles — O Come All Ye Faithful! Proclamations that life's greenery and

vitality exist after all. Deck the Halls with Boughs of Holly! Please have snow and mistletoe. Tannenbaum, oh Tannenbaum.

There is no longer room for negatives such as Bah, Humbug, and the Grinch that Stole Christmas. Away with the imperfect past and present ghosts of Scrooge, only the pluperfect form of Christmas future will do.

In truth, there are many parables, allegories and caricatures associated with the season. Rudolph with his nose so bright guides the toy-filled sleigh unerringly through winter's mists. Frosty comes to life and dances in the streets with the children. Donner and Blitzen alight heavily on the roof and down through the chimney comes old Saint Nick. Ho, Ho, Ho — laughter everywhere.

In this spirit of merriment and optimism, I wish you the best of the season. May winter's snowy mantle fall softly on you and yours and cover your sleep with tranquility and serenity.

God Rest Ye Merry Gentlemen and Women. Peace to you. May visions of sugar plums dance through your heads. And may you awaken to an early spring filled with the promise of well-being and prosperity. Joy to your world. As Tiny Tim was heard to remark, "God Bless Us, Everyone." □

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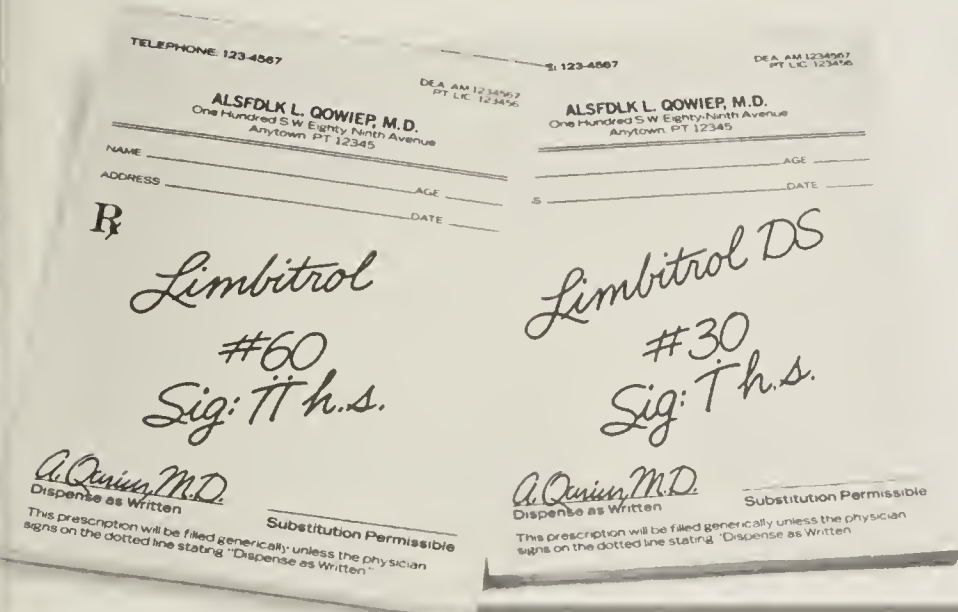
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

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Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

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Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (See Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 50.

ROCHE ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

In the depressed and anxious patient

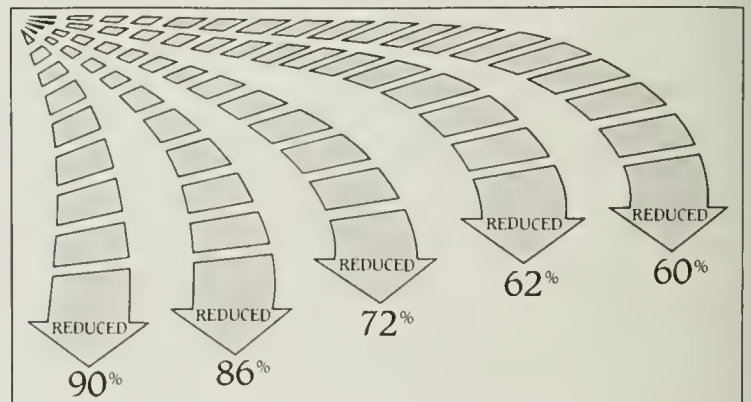
See Improvement In The First Week¹...

And The Weeks That Follow

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➡ First-week reduction in somatic symptoms¹

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



VOMITING NAUSEA HEADACHE ANOREXIA CONSTIPATION

*Patients often presented with more than one somatic symptom.

Limbitrol[®]

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (V)

Limbitrol DS[®]

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (V)

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Please see summary of product information inside back cover.



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